

PHASE 2

IO1 / A6. DEVELOPMENT OF MODULES AND TRAINING UNITS.

MODULE 1. MANAGEMENT OF CPCC MODEL



Open educational resources
for a new model of long-term care at nursing homes,
based on dignity and wellbeing of the elderly

ERASMUS+ KA202

Project number: 2017-1-ES01-KA202-037853

<https://www.newcareproject.eu/>





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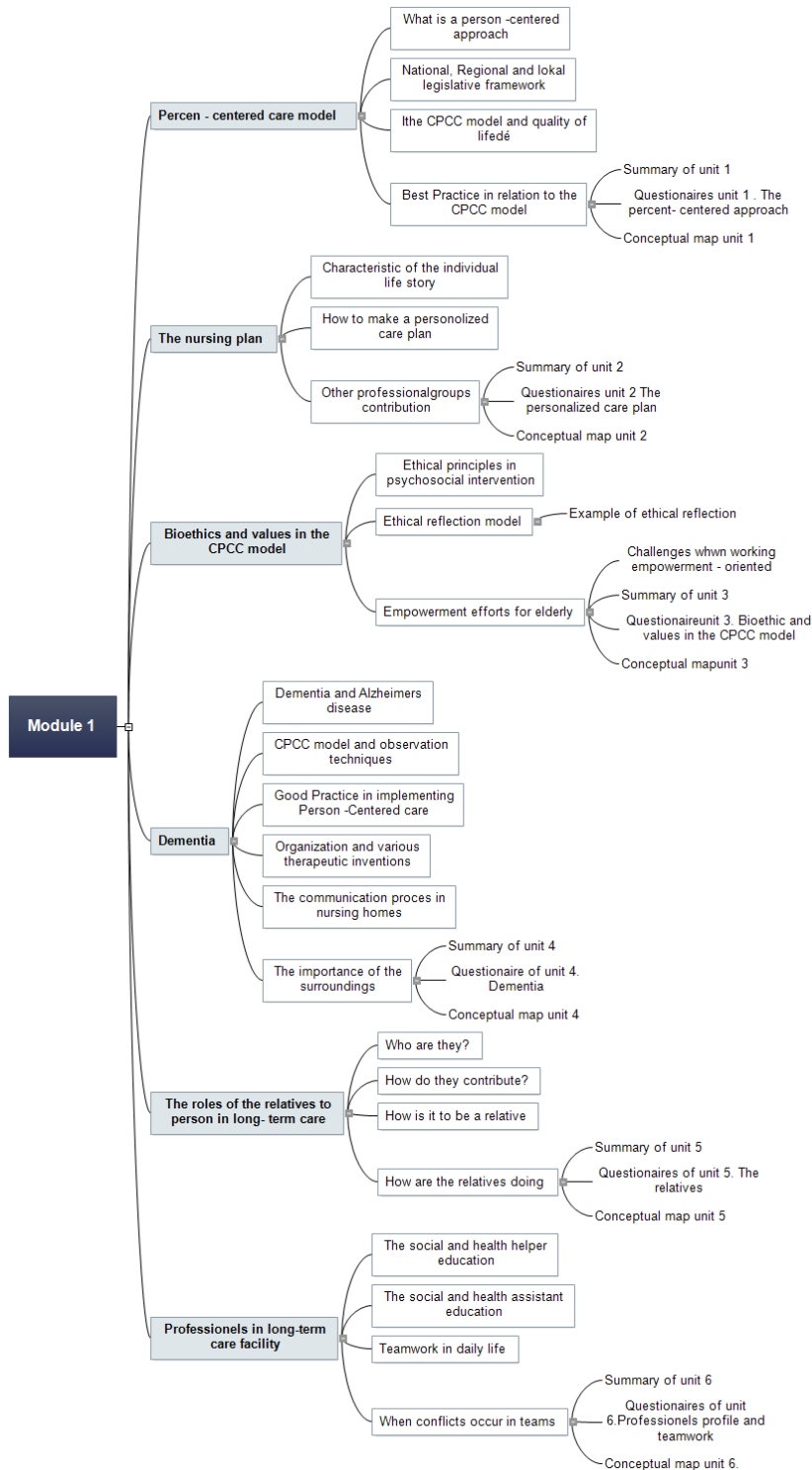
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Module 1. Structure of Learning Content





NOTE

We always use the word “citizen” when we are talking about the individual old person.

The reason is that this is simply the word, which it has been decided to use here in Denmark.

We do not say “the patient” because the person is not necessarily ill – just old – and client does not fit neither

The word citizen has been selected because it indicates that you are having in mind an individual person with rights in society



PRESENTATION

The general objective of this module is to train the reference professional to work more person-centered and be more aware of the citizen's perspective

The specific objectives are:

- Person-Centered care model
- Personalized care plan.
- Bioethics and values in the CPCC model.
- Dementia
- The relatives to persons in long- term care
- Professional of reference in long-term care facilities.

At the end of the learning process, the student will be able:

- To identify the main characteristics and elements of a CPCC model.
- To take part in a multidisciplinary teamwork for the development of a personalized care plan of each resident.
- To be able to involve family, relatives and friends in the development of the personalised care plan.
- To be able to characterize the strategies and the techniques to fostering communication and social relationships with the environment, analysing the principles of social and emotional intelligence.
- To be able to identify needs and critical issues of the relatives and social contacts of the assisted person to analyse social and familiar contest
- To know how to apply bioethics principles and values in the professional performance.
- To be able to choose and plan activities that promote quality of life, taking the level of functioning into consideration.
- To recognize the job tasks and responsibilities of the professional of reference in the long-term care facilities.
- To manage with observational instruments for the identification of capacities and strengths in the elderly.

UNIT 1. Person-Centered care model

1. What is a person –centered approach?

The person-centered approach is defined by the American Geriatrics Society Expert Panel on Person-Centered Care (HAG 64: 15-18, 2016) as: “Individuals’ values and preferences that are elicited and, once expressed, guides all aspects of their health care, supporting their realistic health and life goals”

The article highlights the following key elements / requirements for the CPCC model

Elements that influence the citizen.



- An individualized, goal-oriented care plan based on the citizen's preferences and an ongoing review of the citizen's goals and care plan. The individual is a member of the team.
- One primary citizen or lead point of contact in the healthcare team.

Elements that influence the professionals

- Care supported by an inter-professional team in which the citizen is an integral member of the team. The team must be flexible in its composition and adaptable to changes in the citizen's health status, circumstances, as well as care and life goals.
- Active coordination among all healthcare and supportive service providers. Coordination among all providers assures that all services continue as effortless as possible, particularly when the citizen moves from one site of care (or residence) to another. The primary point of contact mentioned above facilitates this.
- Continual information sharing and communication
- Education and training for providers and, when appropriate, for the citizen as well
- as for other people who are important to the citizen.

Elements that influence both the citizen and the professionals

- Performance measurement and quality improvement using feedback from the citizen and the caregivers.

The care in Denmark is, to some extent, adapted to the person-centered model, but lack of skilled labor, heavy workload and changes in the general health of the citizen challenges the person-centered approach. Particularly within the field of dementia, there is a high level of attention on a person-centered approach.

The above definition is not useful for people with dementia or people with reduced cognitive abilities. They cannot always express their values, preferences and needs. Therefore, as staff, we endeavor to ensure that our care is as person-centered as possible.

There is another snag in this definition, namely the phrase: "as their realistic health and life goals are supported." Who determines what is realistic. In fact, we do not know what is realistic for the individual citizen, many practitioners have experienced that elderly citizens have achieved goals that the professionals did not think possible. It depends on an incredible number of different things, such as support from the family, the effort the citizen puts into his or her own care, and also: do they find it meaningful? Do they have the environment and the money to succeed? Etc.

Tom Kitwood's successors in Bradford Dementia Group, Dawn Brooker introduces the model V + I + P + S as a framework for a person-centered care.

- V represents the person-centered approach as the overall value
- I stand for the individual approach, no two people are the same
- P stands for the need to take the perspective of citizen with dementia, but it also applies to people, who do not have dementia
- S emphasizes the need for a socially supportive environment

The four elements are equally important. The VIPS model directly deals with the citizen, who is dependent of care and not with the organization, but the organization must have the approach as a value basis and have a strong vision that can create a common direction for the work, and should therefore be simple, clear and used in everyday life. Thus, it is important that the staff



have helped create the values and that they have discussed the importance of their daily work within the team.

There is strong evidence that working systematically with the person-centered approach causes fewer conflicts associated regarding the care of the citizen and the citizen are less agitated. In relation to citizens with dementia, the person-centered approach also contributes to the fact that less medication is necessary to be able to handle agitated and unrestrained behavior. In Norway, the VIPS model has been in use in a nursing home and the staff were taught how to use the model, and held structured and regular treatment meetings. The results showed a reduction in agitation levels, in psychotic symptoms as well as a reduction in other symptoms.

In summary:

- Citizens must be treated individually in a manner that reflects their own values. We must be able to see life from the citizen's perspective and support their social life. Everyday life should, as much as possible, be a result of the residents' wishes and needs, and not consist of medication plans, emergency plans and thus like.
- The staff must work interdisciplinary in teams and the citizen must have a single contact person. The team must be flexible, coordinate the services, inform and communicate with each other, as well as other care providers outside the home. In addition, they must cooperate with relatives
- Effort should be made to provide improvement in quality of life for the citizen. Focus on better utilization of social resources.

2. National, regional and local legislative framework.

Denmark is a highly individualized society and the independence of each citizen is the pillar of any legislation. The state or municipality cannot provide any service if the citizen does not wish to receive it, regardless of whether it is diagnosis, treatment and rehabilitation, practical help or assistance.

The Constitution Chapter VIII. § 71. Subsection one. "Personal freedom is inviolable. No Danish citizen may be subjected to any form of detention because of his political or religious beliefs"

Only if a citizen is declared insane and at risk to him or herself or to others, he/she may be admitted to the psychiatric department against their will, according to the "Order of the Act on the Use of Compulsion in Psychiatry"

In Chapter 2. General provisions state:

§ 2) For enforcement purposes according to the provisions of this Act, as far as possible, it is based on the patient's needs and is performed with respect for the dignity of the citizen

PCS. 2. Compulsion must never replace care and treatment.

I § four is as follows

Section 4. Compulsion must not be put into action until everything possible has been done to maintain the patient's voluntary involvement. When circumstances permits it, the patient must have the appropriate time to respond.

PCS. 2. Use of force must always be in proportion to the aim. Whenever possible less aggravated intervention is always the preferred way.

PCS. 3. Compulsion should be exercised as gently as possible and with the greatest possible consideration for the patient, as not to cause undesirable inconvenience for the patient.

The Psychiatry Act only applies to patients admitted to a psychiatric department, as well as to citizens who are forced or subjected to "forced follow-up treatment" after that they have left the hospital.

The starting point for all treatment, including treatment of mentally ill people, is that treatment can only be carried with the patient's consent. Generally, this rule is respected; however, respect for the right of self-determination must not lead to failure to care for psychologically ill patients who need treatment but lack insight in their own disease. Therefore, the Psychiatry Act allows for a degree of coercion in the treatment of mentally ill people.

In order for a citizen to be subject to coercion, the citizen must be declared insane or be in a state that is equivalent to this. Secondly, it is irresponsible not to detain the patient for treatment. The prospect of healing or achieving a significant and decisive improvement in the condition will otherwise be significantly worse or it will put the citizen in significant danger to himself or to others. If these criteria are not met, a patient cannot be legally detained at the psychiatric department.

In terms of both detention and other use of force, it can be difficult to determine the degree. On the one hand, consideration to the patient's self-determination is given, and on the other hand, consideration regarding the patient's need for treatment weighs.

The citizen area is not covered by the Psychiatry Act because people are not hospitalized or need it.

The Service Act covers these areas.

Section VII, Power of Attorney, and other interference with the self-determination of adults, Chapter 24 states

Section 124. The purpose of the provisions of this section is to limit the use of force and other forms of intervention against the self-determination of the citizen to the absolute necessity. These interventions must never replace care, or social socio-educational assistance.

PCS. 2. Prior to any use of force and other forms of intervention against the right to self-determination, the municipality must do whatever possible gets the citizen involvement voluntarily.

PCS. 3. It is always the intention to use a minimum degree of force. The less restrictive measurements are the better for the citizen.

PCS. 4. The use of force shall be exercised as gentle and for as short a time as possible and with the utmost consideration to the citizen concerned and others present, so as not to cause unnecessary violation or inconvenience to all people involved.

If you compare the provisions of the Psychiatry Act with the Service Act, there is a fine agreement: intervention must never replace care, the voluntary road must always be tried first, the use of force must always be in proportion to what you want to achieve and it should be gentle towards the citizen.



In citizen care, action plans should be made for hygiene, for example, if force is used, it is never a lasting solution.

If a citizen cannot take care of him- or herself or his or her own financial circumstances because of developmental impairment, serious brain injury, dementia or other serious illnesses, the citizen will get a guardian. It may be a family member or a duly appointed person (usually a lawyer). Their task is to help the citizens to maintain their right to self-determination

Self-determination and care duty.

A nursing home is the citizen's own home, and she or he has the right to make decisions about his/her own private life, i.e. decisions about private and financial circumstances. Therefore, a thing like restricted fixed hours when the relatives can come and visit the residents – and only within these hours - does not exist. It is the citizens' own home and they decide, who they want to see and when.

The municipality also has the opportunity, under specified conditions, to decide on interference with self-determination in order to avoid negligence of care, if you, due to impaired ability, is incapable to adequately handle your own circumstances.

Care staff should provide the necessary help, in the area of cooking, hygiene, cleaning; activities etc. also if you do not ask for help or even refuse to receive the help.

Thus, there may be a clash between, on one hand, the right to self-determination and, on the other hand, the right to care and thusly the duty of the staff to avoid neglect of care. These are hard decisions that are based on a risk assessment of what happens if you do not get the necessary help for hygiene or other essential care.

If it is determined that the help is needed to avoid maladministration, staff must do all they can to motivate the citizen to receive the help that is their right by law. However, as an overriding reason, the aid is never in the form of coercion except in limited situations, where the staff does not succeed in motivating the citizen to receive the help voluntarily.

Exceptionally, the municipality may decide to allow caregivers to provide assistance without the consent of the resident.

Care without consent will be carried out in the following situations and only under certain conditions:

- Use of alarm and pointing devices if it is dangerous for a citizen or other that the citizen leaves his home or day care or is lost
- Physical detention of a citizen in the home, if it is dangerous for a citizen or others that the citizen leaves his residence
- Retention in connection with necessary hygiene assistance
- The use of fabrics to prevent serious fall injuries

Furthermore, staff can legally restrain a citizen. They are also allowed to lead a citizen into another room in acute hazardous situations, without prior decision by the municipality.

If force is used to provide care, a plan of action must be prepared to indicate what assistance is to be given and how the help should be organized pedagogically and carefully, in order to avoid force when providing assistance in the future.

3. The CPCC model and quality of life

Citizen-centered care is about values and revolves around a care philosophy that emphasizes people's basic psychological needs. It is about meeting the individual citizen where he or she is - and it is about understanding symptoms and behaviors from the perspective of the citizen. Person-centered care requires an individual approach based on the citizen's life-story, dignity, and focuses on the good results.

Person-centered care is an attitude, an approach or an understanding of framework that permeates the approach to the citizen or citizens with dementia. Person-centered care therefore also requires training. One cannot expect that the approach or attitude will be on the backbone of staff right away. However, it does not take longer to carry out. It is an integrated part of the work methods already; one can see that the approach creates better cooperation with the citizen and with people with dementia and thus avoiding a wide range of conflicts.

Person-centered care increases the quality of life for people with dementia

In a major English study *WHELD Well-Being and Health for People with Dementia*, 69 care centers were examined, one half of which received intervention and the other half, which served as a control group, performed normal care. Intervention consisted of systematically educating the staff in the person-centered care and it shows that it has a positive effect on the quality of life of residents and reduces the occurrence of unrestrained behavior. However, person-centered care had no immediate effect on the consumption of antipsychotic drugs, which remained stable at a relatively low level throughout the study period.

The effect of the intervention was measured for 847 resident's, of whom about half of them lived in care centers in the intervention group and the rest lived in nursing centers in the control group.

A statistically significant, albeit modest, effect on the quality of life of the residents and on the occurrence of agitation and other types of neuropsychiatric symptoms and behavioral disorders. The effect was most pronounced for people with dementia in a modest degree. Furthermore, the quality of the interaction between caregivers and residents changed in a positive way.

In another English study (Effect of an enhanced psychosocial care on antipsychotic use in nursing homes for residents with severe dementia), person-centered access contributes with the following:

- contribute to increasing the safety, well-being of people with dementia
- contribute to enhance the integrity of the citizen, independence and initiative
- counteract turmoil.
- Prevent the need for antipsychotic medicine for people with dementia.

In summary, it is clear that there are differences between Danish and English methods, but it is especially in the economic sphere this is visible. There is nothing wrong in comparing English and Danish institutions for the citizen. In the two studies, there is a clear effect on quality of life for people with dementia. It is probably the same for people who do not have dementia;

compared to people with dementia their prerequisites are just better when it comes to maintaining the right of self-determination.

4. "Best Practice" in relation to the CPCC Model

In Denmark, citizens with and without dementia or cognitive impairment, have legislation to support them in regards to citizens' right to self-determination. However, if you are dependent on help, you may need to move residence even if you do not feel like it. A survey from "The Association for Elderly People" from 2015 showed that 80% of the 50-89 year olds did not want to live in nursing homes, even though they would have difficulty managing everyday life themselves.

According to, SFI (The National Research Center for Welfare) 2012 Survey: Every fifth person had the feeling of not having sufficient control over their daily lives. Every fourth person felt that they were missing social contact with people they liked and just as many people said they could not, in sufficient degree, spend time on things they appreciated and enjoyed.

There is currently a trend towards establishing nursing homes on an "Eden basis". As a reaction to the hospital-like conditions in nursing homes. These conditions are being reinforced by society's demands for safety and documentation, rooted in the health care thinking.

In a private home, the daily rhythm is not guided by medication plans or employees' work schedules, and there are no pelvic chairs and linen carts outside the front door.

The visible difference in behavior may be a reaction to, a sense of emptiness, lack of content in life, sorrow over people that have passed away, loss of the life you have lived before, or anger and frustration about the life you have now, and the way you are being treated. Medicine does not remove people's feelings or their cause.

When you are being treated as a disease and not a fellow human being, it affects your self-esteem. In principle, the staff have all the power. However, the staff can abstain from using that power, which implies in practice that the employee must respect the residents' right to plan their everyday life, even when it collides with the schedule.

The nursing home, "Dagmarsminde" is an example of a place where the staff have done the above-mentioned (<http://dagmarsminde.dk/en/>)

The following are quotations from the website of the nursing home.

"You should look forward to moving into a nursing home. It is a big thing to change your everyday live and move to nursing homes. When we meet with you for the first time, we will plan how the relocation will take place. It is expected that the first time at the nursing home may be characterized by being a little confusing to the citizen. How long it takes before the citizen feels at home is impossible to say. However, with "Dagmarsminde's" current residents, we have experienced that it has only taken a few days to feel at home.

Everyday life is the center of the care. Care is about being there for each other when the need arises. At "Dagmarsminde" we believe that we are human because of each other. We are all equal at the nursing home, and we develop mutually when we are together. Therefore, we show our residents how much they mean to us. We, as staff can act cautiously and with great care, in spite of different perceptions of reality. Some of our residents lack disease awareness

and the understanding that they can no longer take care of themselves. On the other hand, they perceive themselves as being healthy and self-reliant - and this should not be taken from them.

A life with dementia must be meaningful. Therefore, we do our best to preserve the integrity and quality of life of each resident. We meet the individual by respecting what makes sense to the resident.”

In relation to the staff, there is also a change in the mindset. “Dagmarsminde” demands “a professionalism that permits dissolving the sharp distinction between the professional and the private sphere,” the idea is that citizen feelings undermine the professionalism, which is considered unacceptable. We disagree with this. We think that expressing your feelings at work is a good thing. To meet the citizen with warmth, presence, human to human in mutual relationships where there is not “a them” and “and an us” but “one we”. Equity means that employees have more freedom and responsibility, and managers must give responsibility. We are not equal in status but we are equal in dignity. “

“Dagmarsminde” reports that symptoms of dementia are reduced by 50% after 6 months’ stay.

Summary of unit 1

The CPCC model has focus on the fact that the citizens must be treated individually in a manner that reflects their own values. We must be able to see life from the citizen's perspective and support their social life. Everyday life should, as much as possible, be a result of the residents' wishes and needs, and not consist of medication plans, emergency plans and thus like.

The state or municipality cannot provide any service if the citizen does not wish to receive it, regardless of whether it is diagnosis, treatment and rehabilitation, practical or assistance. Except for a few exceptions.

Person-centered care requires an individual approach based on the citizen's life-story, dignity, and focuses on the good results. **Person-centered care increases the quality of life for people with dementia.**

Good practice in the CPCC approach begins with focus on of everyday life. Care is about being there for each other when the need arises. We believe that we are human because of each other. We are all equal at the nursing home, and we develop mutually when we are together.

Questionnaires unit 1. Management of the CPCC model

Q1. The CPCC model has the perspective of the staff

False

Q2. If a person does not want to take a shower, you can coerce him/her

False

Q3. The CPCC model increases the quality of life for people in long-term care

True

Q4. The best practice is to treat citizens with dignity and equality

True

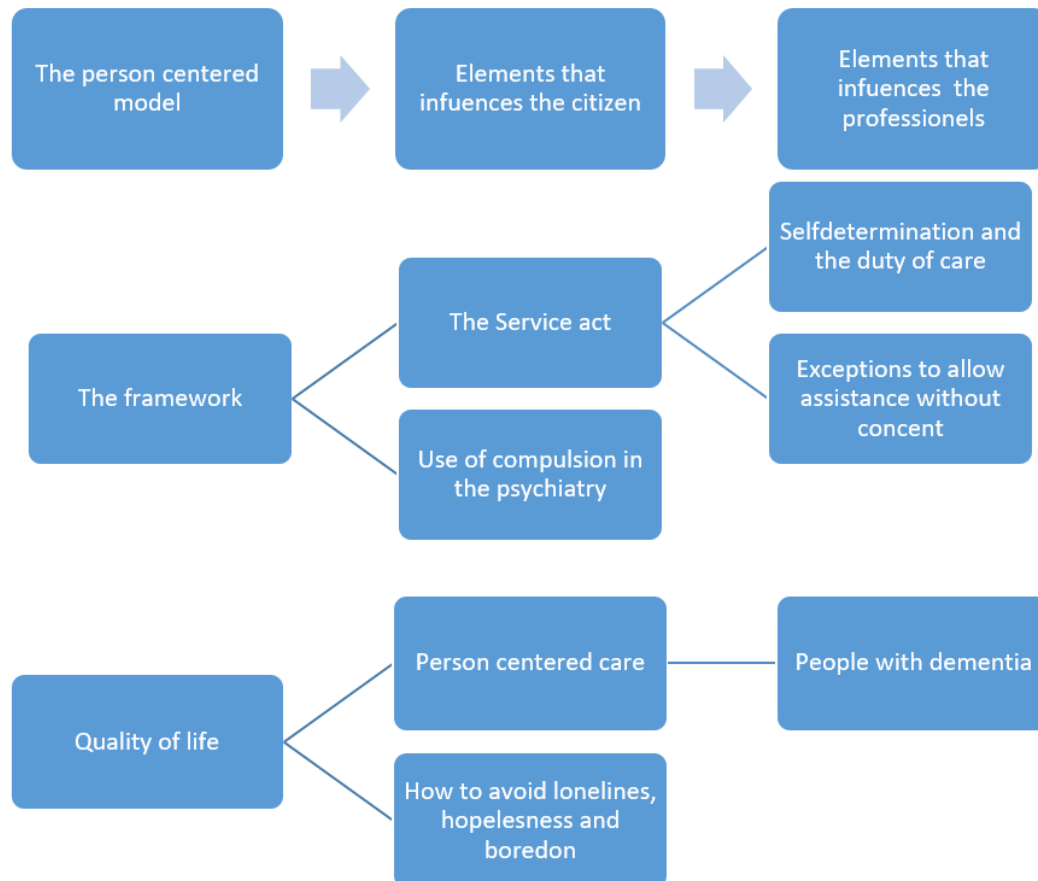
Q5. Teamwork is preferable in the CPCC model

True



Conceptual map unit 1

CONCEPTUAL MAP UNIT 1





Unit 2. The Personal Nursing Plan

1. Characteristic of the individual citizen's life story

The life story can give us an understanding of behavior and thus acknowledge the person's narrative and of the values, the citizen has. The life story provides the basis for organizing activities that the individual citizen perceive to be meaningful.

The life story supports and confirms the individual's experience of identity. No one can preserve the experience of who they are, without relating their story to someone. Both close and distant relations can confirm identity. Every time we meet with others, we seek confirmation of who we are.

In our culture stories are perceived as essential, not only when we intentionally wish to present ourselves in a certain way in relation to other people, but also in the unconscious continuous development processes that are associated with human self-understanding and identity. The self-perception is shaped and developed through the narratives made by the individual. Without telling a story, there can be no identity.

The life story is a representation of the self that occurs in an interaction between three levels of the person:

- The lived life: What actually happens. A life that unfolds consists of the pictures, feelings, views, wishes/desires, thoughts and opinions that the person has.
- The remembered life. The experiences I remember from my life.
- A life that is told. A life story is a narrative that is influenced by the cultural norms of telling narratives, of the audience and of the social context.

The life story cannot be perceived as an exact representation of a course of events. It is the individual's interpretation of the course of life, presented through his personal memory filter. In the life story, the narrator interprets the relationships between the events in their lives. Life stories are stories about people and their relationships with their individual past. Therefore, life stories cannot be seen as an objective expression of a course of events but rather as a subjective expression.

The life story is unique to the individual. The contemporary story is shared with others of the same age (political, social and cultural-historical aspects).

A life story can be of factual nature as shown below:

The factual life story:

Place and time of birth

Parents: Names. What did they do? How were they?

Siblings: Number, birth order of siblings, names, possibly current relations, deaths?

Family life: Celebrations, holidays, and traditions?

Special playmates: Names?

School time: What school, relationship with the school?

Leisure as a child/young person: Interests, duties, work?

Education: Which, where, when?

Children: Number, birthdays, names?

Spouse: Who, married, when, current relationship, death?

Working life: Where, when?

Domestic life: Responsibility area

Leisure/Interests: Areas that has interested the person

Persons with special importance

Politically/religiously important information

Significant habits: e.g. food, personal hygiene, sleep or other?

Alternatively, it may be of a qualitative type, with more positive or negative events and experiences that have been important through childhood, adolescence, adulthood, and old age.

The optimum condition is if it is both factual and qualitative experiences. Both are needed when developing a good care plan.

2. How to make a personalized nursing care plan.

If the citizen lives in a nursing home or a home similar to that, the municipality must develop a nursing plan. The nursing plan must contain information about the overall care and nursing efforts that are needed. This means that the nursing plan must partly be based on the citizen's resources, needs and opportunities, and partly inform about special habits and wishes for e.g. dining times, bedtime routines and activities. The purpose of the development of a nursing plan is to organize the needs of the citizen according to the individual, and it will give both the citizen and the relative's information about the help the citizen receives.

The nursing plan is based on the life story and the current life situation in which the citizen has received care and nursing. To get a comprehensive picture, the nursing process that consists of four main points is applied:

1. Assessment
2. Planning
3. Execution
4. Evaluation

1. The Assessment Phase

- Data collection
- Analysis
- The nursing challenge

Data collection is the first step in the assessment phase. The assessment phase is about assessing the patient's state of health and the overall situation. Data collection must gather knowledge about all the patient areas of need and identify both current and potential needs for care and nursing.

Data is systematically collected to remember all areas of need and to prevent important data from being forgotten or overlooked. Data can be both subjective and objective. Neither subjective nor objective data can stand alone, but complement and mutually support each other.

Data can be retrieved from both primary and secondary sources. The primary source of subjective data is the citizen's own statements. The primary source of objective data is the healthcare provider who has observed the patient - meaning primary clinical observations and measurements. Secondary sources are relatives and journal records, where the information is presented in reproduced form and where interpretation is inevitable.

Data must be relevant, adequate, accurate and valid:

- Relevant and adequate in relation to the patient's current situation.
- Accurate, that means measurements must be made correctly and assessed critically. In the case of the patient's statements, the nurse must ensure that he/she has understood the patient correctly. When describing observations, a specialized language is used.
- Validity means that data must be true and valid. E.g. a measured blood pressure is not valid if the patient is nervous about going to the doctor, because it does not reflect the patient's true blood pressure.

The data collection can be systematized in several ways: Henderson's 14 functional areas, ABC (air, breath, and circulation), head to toe (from head to toe).

Henderson's 14 areas of need

1. To breathe (respiration)
2. To eat and drink (nutrition)
3. To separate the body's waste materials (waste disposal)
4. To walk, sit and lie down, to move from one position to another (mobilization, moving in to different positions)
5. To sleep and rest (sleep and rest)
6. To choose clothes, to dress and undress oneself (dressing)
7. To regulate body temperature (heat regulation)
8. To keep the body clean and well-groomed to protect skin and mucous membranes (personal hygiene)
9. To avoid dangers in the environment, to avoid damaging others (safety and security)
10. To communicate with others by expressing feelings, needs, concerns, or opinions (meaningful contact)
11. To practice own beliefs and values (life values)
12. To work or be engaged in productive employment (productivity)
13. To do recreational activities (well-being and recreation)
14. Learning to discover personal development (development)

(1998. Ingegerd Harder efter Virginia Henderson)

Whatever systematics the healthcare provider chooses, data collection will cover both the citizen's own and a professional healthcare perspective. The data collection must produce the current state of the patient according to the patient's habitual state. The data collection takes place not only when receiving a new citizen. It is a continuous process as long as the citizen needs care and nursing.

2. Planning

- Goals
- Possible interventions

The first step of the planning phase is to formulate goals for the nursing process.

The goals are based on the physical, mental and social issues of the citizen and are planned as far as possible in cooperation with the citizen and his/her relatives.

The purpose is to formulate the goals to suit the individual citizen, and for the citizen to experience the goals as his/her own. The goals describe the desired progression in relation to the citizen's state of health or the pathophysiological phenomena that need to be prevented, e.g. Malnutrition, dehydration, decubitus. Just as there can be formulated goals in relation to the citizen's self-care.

Although two citizens have the same healthcare problems/diagnoses, care goals can be different because the two citizens and their situation are different. The citizens' resources: knowledge, will, strength and skills are necessary to take into account so that the citizen feels heard and respected.

The goals can be formulated according to **SMART's** rule of thumb.

A goal must be:

- Specific
- Measurable
- A behavioural description
- Realistic
- Time indicating

Specific because it must indicate which characteristics have to be measured.

Measurable because it must be possible to evaluate whether the care has had the desired effect.

A description of behaviour because it must express a development of the citizen, e.g. greater knowledge, new skills or that the citizen indicates less pain.

Realistic because it must be possible for the citizen to achieve the goal.

Time indicating because it needs to be evaluated within a short or longer timeframe. Examples:

Short-term goals

- The citizen learns to take subcutaneous insulin injections within three days by him/herself.
- Within a week the citizen becomes well enough to go and open the front door by him/herself.

Long-term goals

- That the patient independently can make appropriate decisions within two months in terms of diet, exercise and insulin if her/his blood sugar level rises above 10 mmol/l.

The goals are prioritized on the basis of consideration of the citizen's state of health, insight into the situation and professional knowledge. For example, respiration and circulation goals

are often prioritized because they are associated with the patient's survival. The goals contribute to the continuity of care and are a prerequisite for the care to be evaluated.

3. Execution

- Reflections in action
- Action

The third stage of the nursing process is called the execution or intervention phase. Intervention means engaging in action. The healthcare provider's intervention may concern both the intervention in an emergency situation and listening to the citizen's statements. During the execution phase, the actions are performed. It is divided into reflection in action and actions. The purpose is to visualize the need for reflection and adjustment of the nursing plan in the nursing course.

The prerequisite for success with the nursing plan is that it is followed. However, when unforeseen events occur where the identified problem cannot be solved as expected according to the planned actions, the situation and the problem must be examined and considered again to find an appropriate way to act. It is about seeing the unknown or unexpected in the situation, and considering what consequences the changed situation has for the care actions. Reflection in action means that the healthcare provider must stop and think about the care situation. The healthcare provider collaborates with the citizen and others involved and makes a professional discretion - i.e. decides how the care can be adapted to the new situation. The qualified professional judgment is based on professional knowledge, insight into the citizen's situation and ethical considerations:

- Health professional relevant knowledge from nature-, human- and social sciences, e.g. Knowledge of the physiology and pathophysiology of the body, knowledge of human reactions to disease and suffering and knowledge of life conditions of the population.
- Insight into the citizen's situation comes from cooperation with the citizen and relatives, where the nurse listens to their perception of the situation and ensures that they have understood the statements as they were intended.
- Ethical considerations are important because care and nursing takes place within human relations. There is an implicit unequal power structure within the relationships, as the citizen needs help and can be weakened and hampered in expressing himself, whereas the healthcare provider has power due to his professional knowledge. The healthcare provider must therefore be conscious that the nursing and caring benefits the citizen, and so patients and relatives feel respected.

The healthcare provider must develop fingertip knowledge and the ability to put a citizen's perspective on the situation in order to quickly make professional estimates and argue for the estimate subsequently. Therefore, the nursing process is not a linear, progressive process. It spirals and jumps back and forth.

4. Evaluation

- Evaluation in relation to goals
- Reassessment

The fourth stage of the nursing process is called the evaluation phase. In this material, the evaluation phase is divided into evaluation in terms of care and reassessment goals with the aim of visualizing that the goals are not always reached and a reassessment is therefore required.

The purpose of evaluating is to develop and ensure a high quality of care. The healthcare provider evaluates the development of the citizen's state in relation to the formulated goals, so it is important to have formulated precise and measurable goals. Evaluation can take place both in and after the nursing process.

The healthcare provider listens to the citizen's and the relatives' assessment of the development and makes his own observations and examinations regarding the development of the citizen's current reactions, state of health, self-care and current level of functioning in order to compare with the described goals for the care.

If evaluation takes place during the course, the purpose is to ensure that the care is still adequate or to adapt the care to the patient's current situation.

If evaluation takes place at the end of the care process, the purpose is to determine if the patient's condition is improved as described in the goals.

Evaluation after ended care process allows for more people to be involved in the evaluation process in order to develop the nursing process.

Below is an example of a care plan from a municipality:

Based on information collected/data it is described how daily care and nursing is organized for the citizen **throughout** the day:

E.g. in relation to agreed visits MORNING – LATE MORNING – MIDDAY – AFTERNOON – EVENING - NIGHT

The individual care plan contains a general description in relation to the following areas:

- Physical: Personal care, eating situations/meals and special considerations in connection to this, medication management, sleep and rest, discharge/toilet habits, mobility and aids, every day rehabilitation.
- Practical: Shopping, cleaning, laundry, foot therapist, hairdresser, etc.
- Psychological: Mental condition, mental illness/illness if relevant, understanding of their own situation and special considerations in relation to communication with the citizen, habits and collaborative ability.
- Socially, spiritually and culturally: Activities, personal interests, networks/relatives and volunteers, etc.

EXAMPLE of an individual care plan:

MORNING:



"Gets help with the lower hygiene in bed and is helped with putting on trousers. The citizen is lifted then on the commode chair and is assisted with the upper hygiene.

The citizen is lubricated with heavy non-perfumed lotion on the back due to dry and irritated skin.

Deo-roll-on is applied. Receives help with putting on clothes on the upper body.

Toothpaste is applied to the toothbrush, and the citizen brushes his/hers own teeth.

The citizen is lifted to the wheelchair.

Breakfast: Junket or yoghurt is served, 1 glass of juice or cranberry lemonade.

Medicine: The citizens is given his/her morning medicine with a glass of water and the staff must make sure that the medicine is swallowed.

LATE MORNING:

The citizen is taken to the centre's cafeteria or to an activity.

Toilet: The citizen is lifted onto the toilet.

MIDDAY:

The citizen eat lunch in the centre's cafeteria, receives a regular serving of food and dessert as well as water.

AFTERNOON:

Toilet: The citizen is lifted onto the toilet.

Coffee, cake and 2 glasses of lemonade is served.

EVENING:

The citizen eats dinner in the centre's cafeteria, 2 sandwiches and a beer is served.

Medicine: The citizen is given evening medicine along with a glass of water and the staff must make sure that the medicine is swallowed.

The citizen is returned to his or her apartment around 8:30 pm.

Toilet: The citizen is lifted onto the toilet.

The citizen is lifted into bed. Wears a small nappy for the night.

A glass of water is put on the bedside table.

NIGHT: Supervision is done approx. at 3:00 am and the nappy is changed.

The individual care plan is followed up/corrected i.e. for new or changed needs.

3. Other professional groups' contributions for the functional assessment of each citizen. **Interpretation of the personal plan and follow-up.**

The care plan is developed in collaboration between citizens, nurses, assistants and sometimes substitute helpers. It is revised whenever the care staff can see that it is no longer up to date e.g. if the citizen has become worse or if the citizen is unhappy with the plan used. The interdisciplinary collaboration between the physiotherapists and occupational therapists is used when needed. It could be in connection with a rehabilitation plan where the physiotherapist should be the primary professionals, or it may be that the care staff addresses the decreasing functioning of a citizen, where the physiotherapist and the occupational therapist can supervise and make a change in the care plan in order to train daily skills and increase the physical fitness. The occupational therapist has specialized knowledge in general

daily functions such as hygiene, dressing and eating. The occupational therapist is especially aware of dinner situations with citizens who have dysphagia problems. Dysphagia is chewing and swallowing difficulty that prevents food and drinks from getting safely from the mouth to the stomach. It is a symptom of various diseases and/or conditions such as apoplexies cerebra, Parkinson, disseminated sclerosis, cerebral palsy, traumatic brain injury, general aging and weakening as well as other.

Dysphagia can result in undernourishment- or malnutrition, dehydration, aspiration, suffocation, aspiration pneumonia. It may be due to a sensory or a motor problem. The symptoms may be coughing when eating and drinking, difficulty controlling the food in the mouth, chewing difficulties, pain when swallowing and especially frequent pneumonia. A new Danish PhD dissertation states that one third of patients who are hospitalized because of pneumonia has dysphagia. It is a worryingly high number, especially as it turns out that the mortality rate for those patients is significantly higher. That way, the difference between having dysphagia or not, becomes a matter of life or death. Therefore, an increased focus has been put this problem in the care sector.

Other professional groups also appear. The interdisciplinary cooperation is characterized by a mix of professionals that the citizen needs. It might be that there is a need for a medical practitioner if the citizen becomes ill, a psychologist if the citizen experiences major crises, a psychiatrist if the citizen is depressed, and a speech therapist if the citizen has trouble speaking after a blood clot, etc. The different professional groups' contributions of knowledge are used in the overall assessment of the care plan. There may also be a transfer description, a rehabilitation plan or something else.

Summary of unit 2

Characteristic of the individual citizen's life story is unique. The life story can give us an understanding of behavior and thus acknowledge the person's narrative and the values, the citizen has. The life story provides the basis for organizing activities that the individual citizen perceive to be meaningful

The personalized nursing care plan is based on the life story and the current life situation in which the citizen is receiving care and nursing. To get a comprehensive picture, the nursing process, which consists of four main points, is applied: assessment, planning, execution and evaluation.

The care staff in long-term care are nurses, social- and health assistants and rarer social – and health helpers. Other professional groups' contributions for the functional assessment of each citizen. Interpretation of the personal plan and follow-up.

Questionnaires u2. The personalized care plan

Q1. The life story is the objective truth

False.

Q2. The life story is the basis of al care

True.

Q3. The care plan consists of four elements

True.



Q4. The care plan makes it easy for the staff

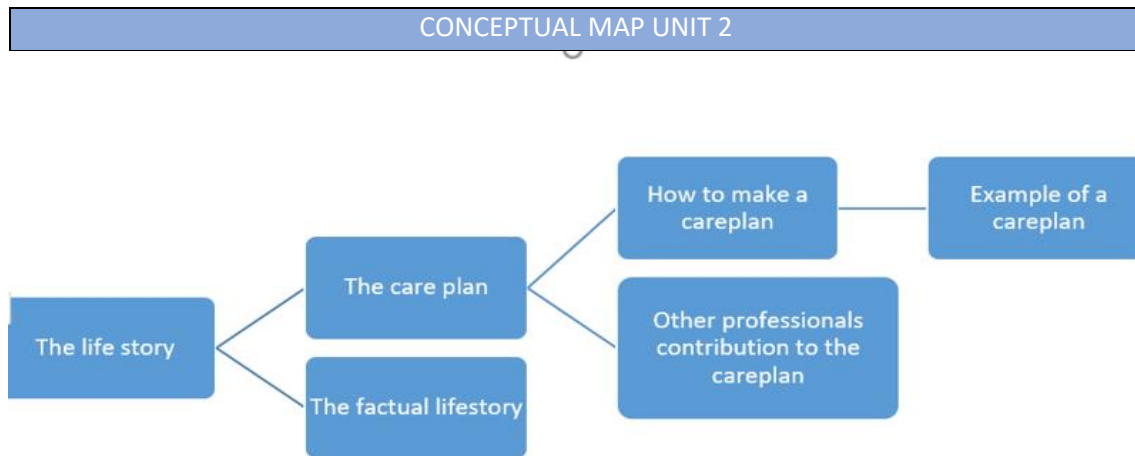
False

Q5. In long term care, the caregivers are the only useful ones

False.



Conceptual Map Unit 2



Unit 3. Bioethics and values in the CPCC model

1. Ethical principles in psychosocial intervention for people with special needs

Ethics is primarily a circumstance and not a necessity that people meet. Norms and values are expressed through our actions. Ethics are the habits that become significant through experiences, and root out the custom that creates a value base in the meeting with others. In Denmark, "The Ethical Council" defines ethics as follows: Ethical issues concerns how to treat other people and other living beings. Ethics is about what the good life is and the importance of taking others into account and not just looking at oneself and one's own needs."

The person-centered approach has shared value with ethical thinking. For several years, Professor Peter Kemp has worked with the practical applied ethics in social work and has worked to find some basic parameters from which ethical reflections can be made.

The four ethical principles he works with are:

- Autonomy
- Integrity
- Dignity
- Vulnerability

These four ethical principles are basic principles that can be said to be of general human nature - and therefore apply to everyone.

The principles also constitute a whole understanding of the fact that when all four principles are kept, there are attention and respect in the social relations. It maintains the ethical level of reflection in relation to the actions we take. Whilst the principles form a whole, it is also often in a position between the principles that ethical dilemmas arise. When you identify and analyse an ethical dilemma, you will often find that the dilemma arises in a situation where you cannot fully respect all the principles, so the principles are in conflict with each other.



Autonomy or the right to self-determination must fundamentally ensure the right to any human being to have and exercise influence on his or her own lives.

The principle originates from the political arena where the concept of autonomy in ancient Greece was used for independent states. Later, the ethical or moral application of the concept came into play and was rooted in the idea that a person is an independent person, who thinks independently. This means that human beings are required to be respected as individual persons.

Three conditions must be fulfilled in order to speak of the fact that a person has autonomy:

- The person must have a certain ability to understand his own existence.
- The person must have an understanding of the consequences his actions has.
- The person should not be subject to compulsion or manipulation.

The right to self-determination thus requires freedom, freedom of thought, freedom of action and freedom of expression - that is, freedom from external force. In order to exercise the right to, and to take responsibility in relation to self-determination, one must have a basic knowledge of their own wishes and, not least, ones needs. Likewise, one should be able to conceive of the consequences of actions and decisions.

Of course, this raises some challenges when we deal with a human being that is not within the "normal" range of rational capacity. However, the right to self-determination is not excluded because the person is not fully capable of exercising it. In many situations, ethical dilemmas will arise when working as a professional authority; you have an increased responsibility for the life and/or everyday life of another person. In other words, you must be allowed to decide in your own life and its actions, provided that it does not violate the right of self-determination. The right to decide over your own life or to act based on a plan chosen by yourself also includes the right to decide that (in certain matters) you will not decide for yourself. This right can then be passed on to a good friend, a relative or the doctor who treats you while ill. However, loss of self-determination does not mean that you also lose integrity. As caregivers, respect for self-determination must sharpen our attention that we are dealing with an individual person, who is independent and who defines the good life for himself.

Integrity.

The word stems from the Latin integer, which means untouched or whole that derives from qualities such as honesty and a coherent character. Integrity can be defined as both a physical and a mental format. Physical integrity may be the social relations or family relationships in which you are born. Physical integrity is also about respect for the physical intimacy. The mental integrity has to do with the person's self-perception. Respect for integrity is respect for the simplicity's own perception of life, values and norms. Including respect for the individual citizen's own interpretation of their life story. Respect for integrity must be present in communicative relationships between humans, but also through stories about others. Distorting and twisting a narrative of others can hurt. Thus, there is an inviolability zone of others that applies to both the physical and mental integrity, which means that other persons must be respected in their diversity and not be taken for granted.

Dignity

Dignity can be defined as a valuation of an internal value found in an object or living being. Humans are defined by having an inherent value that is connected with reason. It is about being aware of the dignity of another human being, by seeing the other as irreplaceable and infinitely valuable. The consequence of this inherent value is that humans must never be treated as a mean for a goal, but always as an end in itself. Dignity is not something to be earned first, that is something you have. Thus, every human being holds a potential value that is only visible when the individual is valued. When we are aware of each other's dignity, we recognize that we as people are basically of equal standing, but doesn't necessarily rank equally. Focus on dignity sharpen our attention that the dignity of the other is placed in our hands. We help to give each other value as well as have the power to deprive the other dignity, for example, by talking behind someone's back, ignoring, making fun of or showing indifference towards others. The United Nations expresses it as follows: "All human beings are born free and equal in dignity and rights. They hold reason and conscience, and they should act towards each other in the spirit of brotherhood." (UN Human Rights Declaration (10.12.1948))

Vulnerability

The term is often used for human relationships, where there is a dependency in the relationship, for example between children and parents or patients and caregivers. We have always been aware of the human being's vulnerability and know that it needs good external circumstances to exist, but it is only in modern times that we have become aware that vulnerability calls for special kind of care from other people. The ethical principle of vulnerability has both a physiological and a mental part, both of which require care. Both the physiological and the mental vulnerability increase the risk of the individual to be hurt by the three parameters: autonomy, integrity and dignity. Therefore, vulnerability needs increased attention from the care provider in terms of maintaining the individual's autonomy, integrity and dignity. We all contain both types of vulnerability and everyone needs care and protection to our vulnerability to a greater or lesser extent. This is why today, vulnerability is not an expression of weakness, but a general human principle – it applies to everyone. Caring for one's vulnerability means that you do not violate integrity, autonomy and dignity, and dare to be present in the situation, even when it can be difficult. We are all dependent on the relationships we form and depend on how others manage the power they have. As a health professional, it is therefore crucial that we act with conscience and care in relation to the citizen's vulnerability.

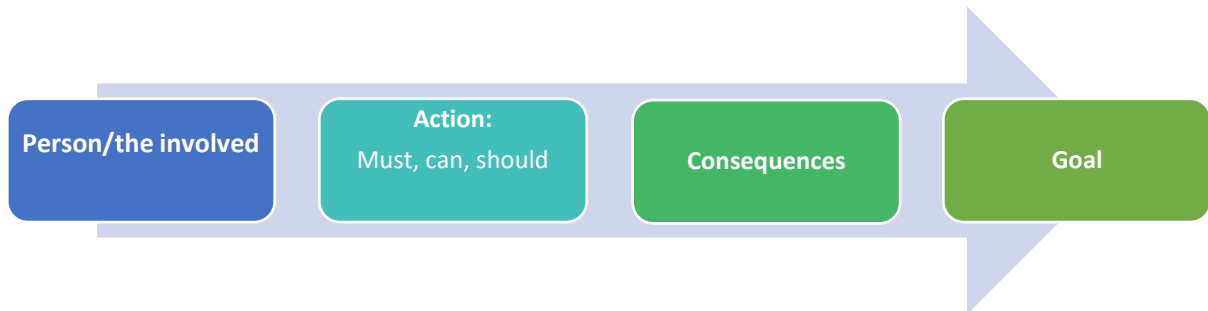
Ethical values as method in Case Management.

As a caretaker, situations that call for ethical reflection will occur. There are ethical dilemmas in which to act. An ethical dilemma is a valuation conflict where a choice must be made between several alternative actions and where the outcome affects other people

2. The ethical reflection model

Reflective work can be done with the ethical dilemma by mapping it out, which includes revealing: Involved parties, possible actions, consequences of the possible actions and the goal of the possible actions.

Thus the action is central to the ethical dilemma, the dilemma lies in the possibilities of action in between: What We Must Do (Legal Obligations), What We Can Do (The Practical/Technical Issues) and What We Should Do (The Ethical Dilemma). Each option of action has different consequences and goals for the parties involved and these should be thought through in order to make the best choice. The ethical choice should always take care of the most vulnerable life.



Case

A woman with dementia who has lost the ability to experience satiety moves into a nursing home. The urge to eat is especially great when she is alone and not distracted by other activities. She is living in a nursing home in a two-room apartment where there is a living room and a bedroom and no kitchen department. From the apartment, there is access to a common living room, dining room and kitchen.

In the kitchen is a fridge from which the residents by themselves can take extra food between the planned meals - also the woman with dementia, who never feels satisfied. This is a great pleasure for the residents and saves the evening- and night staff some time.

However, the woman with dementia, who never feels tired, also uses the fridge, which means that she gains a lot of kilos, becomes overweight and develops diabetes. Her diabetes is difficult to regulate and she is repeatedly admitted to the hospital with high blood sugar.

The ethical dilemma: How can the remaining residents continue to have free access to food without the woman with dementia killing herself?

1. Who are they involved: the person with dementia, other residents, the staff and the manager.

Are there conflicts of interest between the persons involved: The person with dementia cannot manage free access to food but wants food all the time, other residents can manage free access to food. The staff want the best for the capable residents and the leaders want the best for the institution

Action (must, can, should).

What should we do, what does the law say: the citizen has the right to self-determination.

The overeating citizen is allowed to eat as she wishes or the overeating citizen must have help to control her eating, which means that her access to food must be limited. The rest of the residents have the right to eat what they want whenever they want.

The staff are covered by the Authorization Act, which states:



The staff is obliged to act with conscience and care to all citizens. Moreover, in the light of their professional knowledge, to help the citizens in the best possible way.

Authorized staff may be deprived of their authorization if they act negligently (Neglect of care).

What can we do, what is possible?

- a) You can continue as before
- b) The refrigerator can be removed and everyone has food in his/her own apartment/room
- c) The refrigerator can be locked - Other residents have a key
- d) The refrigerator can be emptied in certain number of hours.

Other residents can have their own food or ask for the food to be locked out.

What should you do?

From the vulnerability principle, a solution should be chosen that shields the overeater, who cannot take care of herself. Therefore, one of the 3 latter options should be chosen.

Consequences

For the person: The overeating citizen is very ill with no impulse control. The consequence is that she will kill herself by eating too much. If she gets help, she will have limited access to food for at least 8 hours a day, which means she lives longer. (This is doubtful since she has dementia)

Other residents: They have normal impulse control and thus have no consequence for their lives and health.

The staff: The staff and management must prioritize knowledge of health impacts, self-care, etc. and find a solution that takes care of the vulnerable life and the daily lives of other residents.

If you continue as before, there will be a lack of care for the overeater. The staff do not comply with the legislation.

If the refrigerator is removed and everyone has food in their own apartment/room, it means that everyone has access to food, except for the very ill resident who gets the help she needs. This means that you have to buy food for other residents

The refrigerator can be locked - Other residents have a key. Everyone has access to food. There is being taken care of the very ill. Is there a conflict between the very sick and the other residents? No other food is allowed for other residents

The refrigerator can be emptied in certain number of hours a day. Other residents can have food on their own or ask for food locked out. There is no food available in certain number of hours. There may be purchased food for other residents. It may be necessary to unlock food for other residents

How do we achieve the goal?

That the citizen will get her needs meet without it killing her. What do we choose to implement after we have done the analysis. How do we choose to act in order to reach the goal?

The method can be used to illustrate any practical ethical dilemmas that may occur in the care:



What is the dilemma?

Who are the involved?

Are there any conflicts of interest?

How should we act?

How can we act?

How should we act and what are the consequences for the parties involved when we act in one way or another?

3 Empowerment efforts for the elderly

The definition of Empowerment (Empowerment and Social Work. Social Policy):

"Power, force and strength in which growth in understanding, insight and self-understanding goes hand in hand with an acting and performing power and force. Empowerment is both the one process that leads to action and the product that an action can give.

In dialectic movements that involve and engage individuals, groups and communities. "

The empowerment concept is far from unique and it is used differently in different political directions. Originally, the concept came on the agenda with Paulo Freire's book "Pedagogy of the Persecuted" (1974) which became a widespread strategy for giving the underprivileged power. Freire's definition of empowerment is about awareness raising and building concrete action capacity in relation to changing their own living conditions. The goal is that individuals and groups become aware of the structures and frameworks they act within and understand how to make better use of these frameworks. In order for the term to make sense, there must be persons, groups or entire local areas that have in some way become "disempowered." Therefore, the power concept is essential in empowerment. The starting point is not that power is a constant size. The power perspective in empowerment-oriented social work implies that clients who get more participation and influence do not necessarily reduce the power of the professionals in social work. The ideal is that the overall power increases and turns out to be a "win-win" game.

Here, power discussions refer to the possibilities of influencing their own lives and the external conditions that affect it: e.g. social rights, real opportunities in the labour market or the housing market, etc.

The opposite of empowerment is clientization understood as being held in a passive dependency relationship of a management or of a particular social worker as a result of the asymmetric power ratio between client and professional.

The goal of Freire was to give underprivileged groups knowledge through, for example teaching and thereby making them aware of the structures and frameworks that help create their life situation. In this awareness process, where actors achieve an ability to change their life situation, changes their status from just being an objects to being self-employed and thinking subjects.

You can always discuss who the underprivileged are in a community, but citizens in nursing homes and other citizens with need care are always underprivileged compared to those who do not need help.

If you are empowerment-oriented, you need to work on three levels:

- The individual level
- Group level
- Local community level

Since the individual is always part of a social and political context, all three levels must be involved, but not necessarily at the same time.

The goal at the individual level is an independent and authoritative person. The method is an understanding between individuals and an equal dialogue. This means that the citizen himself decides whether there is a problem and the citizen decides whether to do something about it, the citizen decides what to do with the problem and the citizen determines when the problem is resolved or decides when the problem solving is terminated for other reasons.

The goal at group level is to provide underprivileged groups with knowledge, through education and thereby raise awareness of the structures and frameworks that contribute to the creation of their lives. The purpose is a consciousness in which the group gains the ability to change their life situation so that the actors change from objects to self-employed subjects.

The goal at local community level is that the citizen or group is able to participate in the democratic process and thereby affect the framework and structures.

Empowerment is about both the change of the individual and the changes in the existing power relations in the society. Empowerment is based on a strong belief in the individual's competence and ability to act in relation to improving his situation. The individual can and will take care of his own life. The professional should be seen as a person who provides moral and psychological support and convey knowledge in a given field. It is assumed that the professional has focus on opportunities, is acknowledging and has respect. There must be interaction and an open dialogue. The resources of the individual are identified and trust and true partnerships must be developed to achieve small, secure successes. It is therefore crucial that it is the wishes and goals of the citizens that are in focus and not goals of the professional's

Sherry Arnstein offers an idea of how to work with empowerment using "The Ladder of Participation."

First step from the bottom: The goal is to enable the citizen to engage in dialogue with the outside world, through the professional's interpretation/story/presentation or treatment.

Second Step: To inform about the first step in participation. For example, rights and duties. A successful result is that the citizen becomes aware of his own possibilities.

Third step: Consult or listen to the citizen/participant, through conversations, consultations or user surveys. A successful result is that the citizen shows interest, comes to meetings, etc.

Fourth Step: Advisor Level (Calming - Phase). First step where power is delegated to the participants. A successful result is that marginalized participants get real influence by being adequately represented.

Fifth step: A joint "partnership" is planned. Here is a real exchange of power between the power holders and the marginalized. A good result is when the citizen himself is co-planning and feeling ownership of the plan. Ownership = motivation



Sixth step: The placement phase, the citizen has an overweight of influence. Eg. Does the citizen have veto in relation to the plan. A successful result is when the citizen has a decisive influence on the plan, despite the fact that the authorities may have wanted something else

Seventh and final step: The citizen has full control and power over his own life or over a project. The citizen manages funds based on jointly agreed goals or progress. They are planning and implementing measures.

Challenges when working empowerment-oriented

The challenge for the professionals in this work is the asymmetry of the relationship to power. It can hamper communication and cooperation. If the citizen says, "you only come because you get paid for it," he is right. There are, of course, other reasons, but overall he is right. The staff can assume the "specialist role" and one can easily overestimate their own knowledge in relation to others, for example the citizen. It is difficult to change habits and routines. If you have acted as a resourceful and determined caregiver, you tend to continue it. Finally yet importantly, we cannot ignore the fact that influencing others strengthens self-esteem and becomes a habit fast.

When there is asymmetry in a relationship of power, it requires a lot of attention from the employee so that the citizen's self-determination right is not overridden for the sake of the organization. Examples of this are common and many: If a citizen is admitted to the hospital, he immediately joins the hospital routines, usually without complaining because he wants to be quick. If a citizen needs home care or moves in a care home, he will also promptly be subject to the routine of the place and the staff. If the individual citizen or their relatives question the routines of the organization, they are very easily thought of as difficult. To give power is rare if it is not a conscious choice.

For the citizen, the challenge is to maintain the right to self-determination in a difficult situation, it can be easier to give responsibility and influence especially if you are ill and weak, but it is much more difficult to relieve the power, especially if you are still dependent on treatment or services.

Summary of unit 3

Ethics is about what the good life is and the importance of taking others into account and not just looking at oneself and one's own needs." The person-centred approach has shared value with ethical thinking. There are four ethical principles: Autonomy, integrity, dignity and vulnerability.

Action is central to the ethical dilemma; the dilemma lies in the possibilities of action in between: What We Must Do (Legal Obligations), What We Can Do (The Practical/Technical Issues) and What We Should Do (The Ethical Dilemma). Each option of action has different consequences and goals for the parties involved. The ethical choice should always take care of the most vulnerable life.

Empowerment is about both the change of the individual and the changes in the existing power relations in the society. Empowerment is based on a strong belief in the individual's competence and ability to act in relation to improving his situation. The individual can and will take care of his own life. The professional should be seen as a person who provides moral and psychological support and convey knowledge in a given field.

Questionnaires u3. Bioethics and values in the CPCC model

Q1. The ethics and the CPCC model shear values

True

Q2. The ethical reflection model is used to find the right professionals

False

Q3. There are four ethical principles: Autonomy, integrity, dignity and democracy.

False

Q4. Empowerment is giving back the power to people who has been disempowered

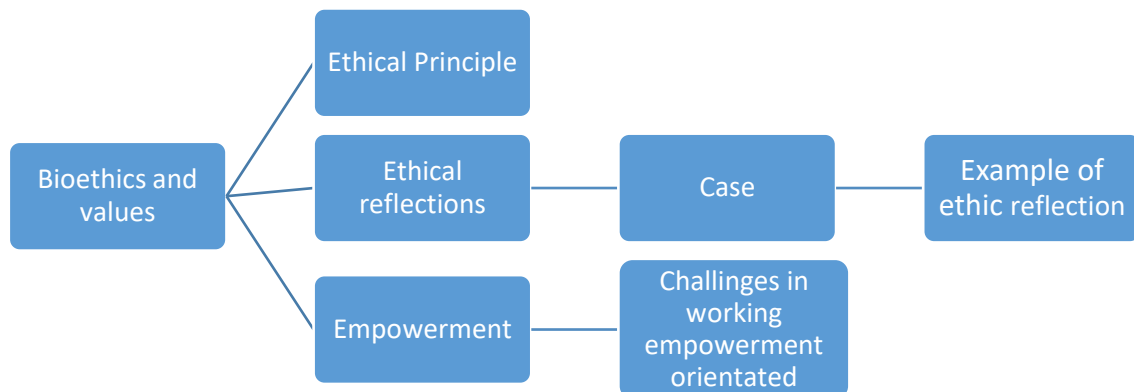
True

Q5. A challenge in working empowerment orientated is to hang on to one's own power

False

Conceptual Map Unit 3

Conceptual Map Unit 3





UNIT 4. Dementia

1. Dementia and Alzheimer's disease.

Dementia is a collective term for the state of a number of diseases, which is characterized by permanent weakening of mental functions. Dementia is therefore not a specific disease, as many different diseases can cause dementia. Around 200 different diseases can cause dementia or cognitive disorders. Alzheimer's disease is the most common cause of dementia. About 60% of people with dementia have Alzheimer's disease. Dementia is a disease, not a consequence of getting old. It is a myth that dementia is a natural consequence of getting old, but it is such that the risk of dementia increases with age. There are only a few diseases that give dementia that can be cured. However, several diseases can be treated to some extent, so it is important to have a diagnosis

Symptoms of dementia.

Most people with dementia suffer from memory problems, but other mental skills are also affected. It can be:

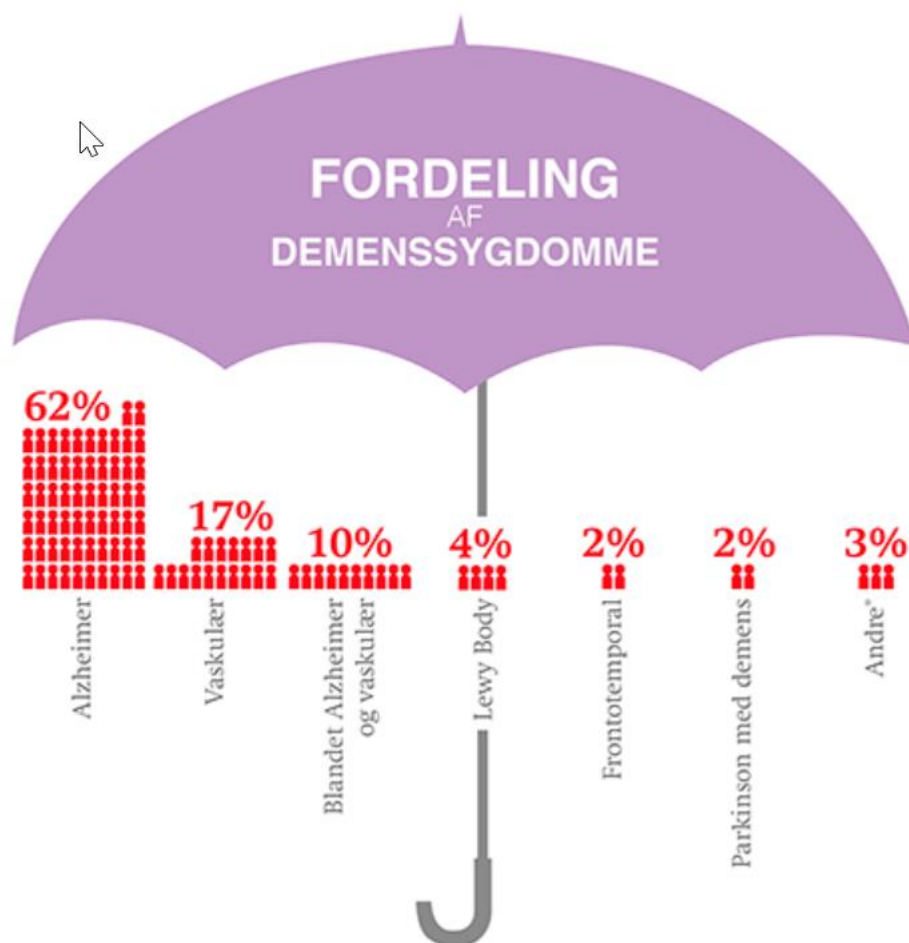
- Initiative and action
- The ability to find words and names
- The ability to find a way (location)
- Numeracy
- Overview and problem solving
- The ability to remember personal names

The person with dementia can change, social skills, emotional life and personality can be affected. This means that it will be harder for the person to overview the social interaction and he/she may find it difficult to get into the situation of others. The person can also lose his situational awareness. All people may find that there are some things that they cannot remember, but if it affects a person's ability to cope with his everyday lives, there is reason to suspect some kind of dementia

Diseases associated with dementia are divided into three categories:

1. Neurodegenerative diseases. Neurodegenerative diseases are diseases where a gradual, often slow breakdown of the brain and its functions occurs. For example, Alzheimer's disease, Frontotemporal dementia or Lewy body dementia.
2. Vascular dementia. Vascular dementia is dementia caused by disturbances in the brain's blood supply or blood vessel. The disturbances may be due to blood clots, bleeding or narrowing of the blood vessels of the brain.
3. Other diseases. A number of other diseases with direct or indirect influence on brain function can cause cognitive impairment. For example, there may be metabolic disorders, chronic deficiency of B vitamins or poisoning conditions

The distribution of the different categories of illnesses:



Kilde: <https://www.alzheimer.dk>

The figure shows the distribution of different diseases causing dementia in Denmark. 62% has Alzheimer's disease, 17% has vascular dementia, 10% a mix of Alzheimer and vascular dementia, 4 % has Lewy Body dementia, 2% has frontotemporal dementia, 2% has Parkinson with dementia and 3% is caused by other diseases

The disease process depends on the cause of the disease. Most dementia diseases are progressive disorders that cannot be cured. The course may vary from year to several decades. Dementia diseases are generally not hereditary. In Alzheimer's disease, only 2-3% of the cases are directly due to inheritance. The reason for the other cases of Alzheimer's is more uncertain.

Frontotemporal dementia is the common name for a group of relatively rare diseases, which account for only 5-10% of the total number of dementia. Frontotemporal dementia is more common inherited, as up to 40% of the cases are genetically conditioned.

The possibility of treatment is different depending on which disease is the basic one. Counseling and practical assistance, care and relieving of relatives are important elements of the treatment. In addition, doctors in Denmark, since the 90's have been able to prescribe medications that temporarily dampen the symptoms of, for example, Alzheimer's disease. In vascular dementia, which may be due to blood clots in the brain, the treatment aims to prevent the formation of



more blood clots. Some of the diseases can be cured, e.g., metabolic disorders, depression, side effects or misuse of medicines. It is important always to clarify what is the cause of the symptoms. It is therefore important to be diagnosed as early as possible

Characteristics of Alzheimer's dementia

Alzheimer's dementia is by far the largest proportion of people with dementia. Typical symptoms are memory problems, especially short-term memory is affected and one has trouble finding the right words, especially nouns are hard to remember. Everyday life is affected because it becomes harder to overlook ordinary things like finding out, counting money, paying, etc. As the disease develops, changes in emotion, temperament and social engagement can occur. People who have been open and social are being retrenched and confined and the mood can fluctuate a lot. The symptoms develop slowly and the person may think that he is just tired or stressed. Gradually, the symptoms become harder and the surroundings begin to notice that something is wrong. The person can no longer take care of a job nor make his everyday work. Therefore, help is needed and in the longer term, a care home will be needed.

The course of illness lasts an average of 8 to 10 years.

The cause of Alzheimer's dementia is unknown. Nevertheless, researchers can describe some of the changes that occur in the brain. There are accumulation of harmful protein substances between both the brain cells (beta-amyloid plaques) and inside the brain cells themselves (Tau jointing). The disease also causes a lack of the signal drug acetylcholine, which the brain cells use to communicate between each other. Both kinds of protein deposits can be seen in other dementia diseases, so it is the combination and distribution in the brain that is special for Alzheimer's disease. In the case of Alzheimer's disease, the areas of the temporal lobe that control the memory are usually affected. Therefore, the memory is especially affected. As already mentioned, it is estimated that 2-3% of Alzheimer's disease is inherited, and you distinguish between an early and a late debut.

It is typical of Alzheimer's dementia that it develops after the age of 65 and this type is not hereditary. But the other types which is inherited or due to mutations can affect already at the age of 40. The main risk factor for Alzheimer's disease is high age, but living conditions and behaviors that increase the risk of cardiovascular disease are important, for example high blood pressure, diabetes and smoking.

Characteristics of vascular dementia

Vascular dementia is the second largest group of dementia diseases. The symptoms are very different here as it depends on which areas in the brain are affected. There may be forgetfulness, difficulty in concentrating, language problems, and more. There may be hemiparesis and consequently difficulty in walking, disturbed tactile sense or narrowing the field of vision. If the person is hit in the deep structures of the brain, the person can become apathetic and the thinking gets slower, you get trouble concentrating when solving more complex tasks. Persons with vascular dementia often show depressive symptoms. One's emotional expression can fluctuate a lot, one cannot control cry or laughter, and emotional responses can emerge in situations where one does not feel sorry or happy.

Vascular dementia can be caused by blood clots, bleeding and disease in the small vessels in the brain, by changes in the brain's white substance or failure of oxygen to the brain. Unlike, for example, Alzheimer's disease or Lewy body dementia, vascular dementia is not a neurodegenerative disease and the condition is not necessarily progressive. The symptoms of vascular dementia vary, as both the number and size of the vascular lesions, as well as the location of these, affect the symptoms and the degree of dementia. In some cases, there has been one or more strokes (apoplexies) with sudden onset, half-sided paralysis or speech impairment prior to the development of dementia. In other cases, the changes in the brain gradually occur without the occurrence of stroke. The most common cause is blood clots in the brain.

Vascular dementia cannot be cured, but one can do much to prevent the disease from getting worse. This prevention may be that the doctor prescribes blood pressure regulating, blood thinning or cholesterol lowering medication just as any diabetes should be well treated. The risk factors are almost the same as for cardiovascular diseases. Our lifestyle affects several of the risk factors. It is important to exercise, eat healthy and avoid smoking because it both reduces the risk of cardiovascular disease and vascular dementia. If you have diabetes or high blood pressure, it is crucial to be treated.

Vascular dementia is not inherently in itself. Some of the risk factors for vascular dementia are partially hereditary, but are highly influenced by lifestyle.

Characteristics of Lewy Body Dementia

Lewy body dementia is a neurodegenerative dementia disease that, in addition to dementia, also can cause movement disorders resembling the symptoms of Parkinson's disease, as well as visual hallucinations and alternating attention. There may be shorter or longer episodes where the person seems distant, unclear or confused, but the condition may change from day to day and from hour to hour. The person may seem dull, indifferent, tired or numb, stares out into the air for longer periods and sleeps more than usual during the day.

The person's ability to plan, overview and orientate is influenced. Lewy body dementia also means that the affected person has a tendency to see visions during periods. The visions are usually quite lively, detailed and natural, e.g. in the form of people or animals that are present in the room without saying anything. The visual hallucinations do not necessarily seem scary. Three out of four patients get worse in walking and developing slow and rigid movements. The agitation disturbances recall the symptoms of Parkinson's disease. The fine motor control also gets worse, the speech becomes lower and slower, and there is less mimic. Lively nightmares and troubled movements disturb some patients sleep. Sleep disorders may develop several years before the other symptoms and occur frequently.

Lewy body dementia is the third or fourth most common form of dementia. Lewy body dementia can even be difficult for specialist physicians to distinguish from Alzheimer's disease and Parkinson's disease, which contributes to the uncertainty about how frequently the disease occurs.

Lewy body dementia is a slow progressive brain disease that specifically affects older people. The reason for Lewy Body dementia is unknown. Hereditary forms of this disease have not yet been found. The greatest risk factor for the disease is age. By Lewy body dementia, a particular protein

is deposited within the brain's nerve cells and forms the so-called Lewy Bodies, which has given the disease its name.

There is no cure for Lewy body dementia, but medicine can temporarily dampen the dementia symptoms. It develops slowly and gradually, and often begins with changes in awareness or state of consciousness. The average debut age is around 75 years, which is about the same as for dementia of Parkinson's disease. Lewy body dementia is not described earlier than about 50 years old. There are no known risk factors for Lewy body dementia beyond age. The disease is more frequent in men than in women.

Characteristics of Frontotemporal Dementia

Frontotemporal dementia (often-abbreviated FTD) is not the term for a particular dementia disease but a common name for several different diseases, particularly affecting the frontal lobe. It is the fourth most common cause of dementia and represents a place between 5% and 10% of all cases of dementia in Denmark.

Frontotemporal dementia manifests itself in the form of gradually increasing changes in personality, behavior and / or language and differs from Alzheimer's disease because learning and memory may be intact in the process of the disease. However, the disease means that inhibitions of impulses and situational judgment perceive or disappear and the patient receives impulsive and uncontrolled behavior and indifference to social norms. For example, the person may tend to eat or drink too much. The symptoms may look like certain psychiatric diseases, and frontotemporal dementia can therefore be difficult to diagnose. For example, at the beginning of the process of the illness, the doctor may think that it is a crisis action or a mania.

The cause of frontotemporal dementia is unknown, but 40% of the cases are hereditary.

Frontotemporal dementia is associated with several different brain disease processes. There are, among other things, detected swindles of the frontal lobes, swollen brain cells and accumulation of a particular type of protein (Tau) in the brain. In some subtypes, the temple lobe are hit before the frontal lobes. Frontotemporal dementia cannot be cured and there are no drugs that slow down the disease. However, it is very important that the citizen and family members get the right advice and support early. Disorders of behavior and psychiatric symptoms are primarily dealt with by a specialized social education effort and by adapting the housing and environment in which the person lives.

Frontotemporal dementia often debuts earlier than other dementia diseases, typically between 55 and 65 years old, but it can also happen much earlier. The average survival time is from six to 8 years. However, some have lived with the disease for up to 2 decades.

Characteristics of other diseases.

There are a number of diseases that contribute to dementia. Here we will just mention a few since they do not affect as many people as the four above mentioned types

- Alcohol-related dementia: Dementia caused by alcohol abuse does not constitute a well-defined disease state. It is uncertain whether it is alcohol itself that has a lasting harmful effect on the brain or whether the harm is caused by, the unhealthy lifestyle often associated with alcohol abuse.



- Huntington's disease is a pronounced hereditary disease. At Huntington's disease, there is often a mixture of neurological and psychiatric symptoms and often dementia in the late stages. Symptoms may vary from person to person, but there are usually different degrees of involuntary chorea, uncertain gait and possibly more twisting movements (dystonia). Dementia is not seen in everyone. It develops slowly and only later in the process. In addition, delusions and depression may occur. In Denmark, there are around 300-400 patients with Huntington's disease.
- AIDS dementia is rare today due to the improved treatment.
- Creutzfeldt-Jakob's disease. There are approx. five new cases in Denmark per year. In Denmark, there have not been any cases of the new type, called new variant CJD, also known as "Mad Cow Disease".
- Disseminated sclerosis is a disease in which the body makes an inflammation reaction (inflammation) that destroys the isolation around the nerve threads. Disseminated sclerosis can develop dementia. There are also other rare inflammatory diseases that can affect the brain and give dementia
- Poisoning. Certain heavy metal poisons, including lead and mercury, and prolonged exposure to organic solvents can cause memory and concentration weakness as well as dementia.
- Metabolism. These diseases are rare causes of dementia. There are different types of body metabolism processes that can affect the brain, so it causes dementia symptoms.

2.The CPCC model and observation techniques according to Tom Kitwood.

The person-centered approach was already described in the 1920's where the German philosopher Martin Buber talked about an "I-you" relationship as opposed to an "I - it". The human being before the disease. Carl Rogers, a psychologist, talked about the person-centered approach in the 50's therapeutic relationship, and Tom Kitwood talks about person centering in relation to people with dementia. His approach should be seen as a criticism of attitudes and actions in the care of people with dementia. A care that emphasizes the person's disease and disabilities. According to Kitwood, the person-centered approach is to see the person with dementia as an equal person with feelings, rights, wishes and a life story that has affected the person before receiving a dementia. Therefore, a person with dementia must be understood from both a biological, a psychological and a sociological perspective. Kitwood has made an alternative definition of what dementia is and what factors affect the individual with dementia. Definition = P + B + H + N + S

- Personality - the person's resources and defense mechanisms
- Biography - life story / life experiences
- Health - physical condition and sharpness of senses
- Neuropathology - changes in the brain cells
- Social psychology - conditions in the environment - how do we meet the person

The staff cannot do anything about the personality if the person has dementia, but one can take the background of the individual into account, his resources and limitations. The

biography and life story is as it is, but it is a good starting point for any action. We must pay attention to the health of the citizen as a whole, often the individual has more diseases or an acute disease, and dementia is not the only disease. Citizens should of course be treated in case of a possible illness. We do not know much about the neuropathological changes in the brain. Medicine works for a period and can improve the ability to function for a period but the effect is not lasting. As a staff member, we need to take into account the abilities of the individual and ask for each person with dementia what is relevant for their level. On the other hand, we can do a lot in relation to social psychology. How do we relate to the person and how do we create an environment that the person can enjoy?

Kitwood emphasizes that the person retains his value as a human being throughout the process of the disease. This implies that you get the opportunity to engage in relationships that you appreciate and where you, yourself are appreciated. As a human being, one needs to be valued in a community. We are as people dependent on each other's recognition, respect and trust. These needs do not disappear because you get dementia, but it gets harder to express your needs. It is up to the staff to be aware that these basic human needs are met. The person with dementia cannot do it himself.

In his work, Kitwood emphasizes six psychological needs that are essential to all people:

- Love: unconditional acceptance and empathy.
- Comfort: the person needs security, warmth and proximity.
- Identity: is connected to know who one is and have a connection with the past.
- Attachment: linking ties, relationships with others. To experience confidence and trust in the relationship, so that you have someone to go to in difficult situations.
- Meaningful employment: to participate in your own life in way that you use your abilities and strength and experience that you are needed and that you have something to do
- Inclusion: Being part of a social community and feeling accepted.

People with dementia need support to meet these universal needs.

Tom Kidwood believes that what he calls malicious social psychology can affect people with dementia so they get worse and worse and ultimately do not interact with the outside world or it can cause serious behavioral problems. The following are examples of what he means when he says malicious social psychology:

1. Threats: to instill fear by using threats or physical power
2. Neglect: Refuse to give the attention or fulfill an obvious need
3. Too high pace: To give information too fast, to present choices or to expose the person to pressure to make things faster than person may endure
4. Treat like a child: To treat a person downloading as if he were a small child
5. Put stickers on persons: to prosecute or mention the person in an abusive way
6. Downward assessment: to tell a person that he / she is incompetent, useless, and worthless



7. Complaint: - To accuse a person of actions or lack of action arising from the person's inability or misunderstanding of the situation
8. Treason: To use forms of deception in order to distract or manipulate a person or force them to be compliant.
9. Undervalue the person: Not to recognize the persons the subjective reality or feelings
10. Incapacitación - Do not allow a person to use the abilities he actually has; not being able to help him complete completed actions.
11. Interference: - Force a person to do something to override the desire or refuse the appropriate options
12. Interruption: - interferes suddenly or interfering with a person's action or consideration: to commit gross breach on their frame of reference.
13. Objectification: To treat people as if they were dead things.
14. Stigmatization: To treat a person as if they had died from the outer room or a scum
15. Ignore: Continue speech or action with a third person as if the person is not present.
16. Banishment: To send a person away or to exclude him - physically or mentally.
17. Open up to ridicule: To make fun of someone's "strange" actions or remarks, teasing, humiliating or joking at the expense of the person.

Kitwood considers it as a conscious or unconscious as part of our cultural heritage, that we think that people with mental disabilities are inferior. They are parked and treated accordingly.

It requires constant conscious work with the person-centered model to avoid any of the above examples sneaking into care. It requires openness in the team of employees and management, so any downward treatment does not get a foothold in the care.

The opposite of malicious social psychology is "Positive Person Work". It represents a new care culture focusing on everyday life and community. The positive personal work is what helps build the self-esteem and dignity of person with dementia and contributes to well-being and quality of life.

3. Good practice in implementing person-centered care of people with dementia in nursing home.

In order to implement the person-centered care in an organization, it is necessary to have a clear vision and an instruction on how to reach the vision. The vision must create a common direction for the work and be a collaboration between management and employees. In the daily work, the leader must go ahead and show that the goals and vision must be respected. Tom Kitwood believes that treating his own staff "person-centered" is a prerequisite for developing the desired care culture. There is a need for the staff of an organization to feel recognized by the leader being included and respected in the community.

Management must give the staff individual freedom and responsibility to always act in the interests the person with dementia within the current framework of care. A person-centered care culture implies that the organization is open to and provides room for learning and development.

The person - centered approach implies that the staff work with the citizen's personal goal



care plans based on the person's preferences and goals. The goals revise on a continuous basis. The citizen must be considered a member of the team and the citizen must have a contact person

Work in multidisciplinary teams is the preferable, teams that are flexible and that can adapt to changes in the citizen's health status, circumstances, need for care and life goals. There must be an active coordination of all actions. Coordination is especially at the center when the citizen moves from one place to another. It is the task of the contact person to put it into practice. The team must communicate and share information continuously to all care teams. It is especially when a person crosses different administrative sectors that there are challenges in creating a well-coordinated process

Education and training is necessary for the staff and it may be necessary to train the relatives. In the work with the person-centered approach, it is also necessary to measure whether the efforts work and contribute to improve the quality. This can be done using feedback from citizens, relatives, and staff.

The individual employee will need to have a number of skills to work with person with dementia in a person-centered approach.

The employee must

- appreciates the person with dementia, as a unique and equal person despite the mental deficiency.
 - organize an individual care and treatment based on the specialness of each individual.
- Try to understand what is best for the person with dementia from the perspective of the person concerned.
- protect the person's self-determination, rights and opportunity for co-determination.
 - See the person with dementia as an active partner.
 - Seek to involve the person's social network in care
 - Try to establish a personal relationship with the person with dementia
 - Create a supportive environment around the person

In addition to basic physical needs, it is therefore essential that the staff generally focus on the fact that every citizen needs:

- Support in maintaining his identity.
- Help to make the most of their resources.
- Help to remain an independent social person.
- Help to maintain his identity as far as possible.

In particular, there is a need for specific professional skills in dementia, such as knowledge of social education impact. Focus on the whole human being and the important life story and on the fact that the citizen's day has 24 hours. It is necessary with specific relational skills for these cases:

- The citizen lacks insight in his/her own disease
- There is an out reacting citizen
- An unhappy citizen
- Younger citizens with dementia
- Collaboration with relatives.



- Citizens with non-western background

In addition, skills are needed to deal with dilemmas, reflection and reasoning.

4. Organization and various therapeutic interventions.

How do you create a good life in the nursing home despite the citizens' disability? Here the person-centered approach is also the key. We need to find out what it is that the individual appreciates and use that as starting point.

More generally, one can say that it is about avoiding what the "Eden" founder Bill Thomas calls "care disorders": loneliness, helplessness and boredom.

- Loneliness: Is the pain we feel when we want, but cannot share the presence with anyone.
- Boredom: Is the pain we feel when we lack variation and spontaneity in everyday life
- Helplessness: Is the pain we feel when we always receive care and do not get the chance give someone our care

("As it used to be at home" by Ulla Skovsbøl in cooperation with Eden Denmark by Åse Porsmose and Karin Dahl)

The focus in the nursing home should primarily be, the residents' home and then secondly a workplace. Everyday life should be governed by the wishes and needs of the residents instead of medical plans, care schedules and the like. A real home, where residents at least determine more and where equality in human relationships affects everyday life. There must be focus on cosines, everyday life and the individual person.

Everyday life in focus.

The idea is that residents have a real influence on their own lives, and it is their own habits and needs that largely govern everyday life. Daily doings such as meals, laundry and cleaning should no longer take place far away from residents, but close to them, and in cooperation with them. A nursing home is a place where people who need care can live and live a life that meaningful for the individual. A life where not only the care of the body is important but also social activity. Throughout a long life, we do many tasks daily and consider at a number of big and small tasks. Every day's many small tasks are important for the experience of identity. Everyday activities can also help to avoid further loss of function and with age, greater effort is required to avoid function and skills loss, as age-related physical capacity drops (e.g. muscle strength) bring older people closer to a critical physical capacity threshold, it is necessary to perform daily tasks. Put in another way, it increases the vulnerability of the elderly as their reserve capacity decreases.

Everyday life is composed of activities and participation and the importance we attach to, for one person it is important that they get a specific cup for the morning coffee, for another it may be very irrelevant. It is necessary to understand the differences between people's everyday lives.

Every day, there are habits and we fulfill certain roles based on the values we have. Habits enable me to recognize a situation and act without consideration, attention and reflection. That is, permanent habits enable automated behavior. Therefore, habits are good as they create peace of mind, they are known. Roles regulate which behaviors are in order and organize the daily activities. If I am a housewife, I'm expected to act in a certain way, so roles affect the way and content of the interaction. Roles require solving routine tasks. Should you



be a host at a party, it cannot be discussed who says, "You are welcome". In addition, roles divide daily and weekly courses into time blocks when we perform different roles in a week. Perhaps we attend church on Sundays or meet with old work colleges on Tuesdays. Many elderly at nursing homes suffered a massive loss of roles. Family roles sometimes is only ones left and they may be hard to fill in, as the person want too. Lack of ability to maintain roles, values, and interests influences the beliefs of older people in their own ability to act negatively. For the most vulnerable elderly, the construction of a fragmented self-image can be supported when they are with people who knew them as they were before they got dementia.

To be able to engage in significant activities recognized in one's culture affect health, well-being, and help make life meaningful. Feeling useful, having control, creating and maintaining contact with other people allows for personal development and, not least, self-confidence. It can be difficult to find out which activities make the individual happy, here is the life story important, otherwise, one must be observant in their approach to the individual. Various activities general meet human needs. For example, it may be difficult to meet the need for warmth and touch when you live in nursing homes; many are only touched, in intimate care situations of care. Therefore, most people find that stimulation of the tactile sense is nice; it may be scalp, facial or foot massage or a spa bath. The other senses can also be stimulated through music, dance or singing. Taste and smell is stimulated when we cook or bake together with the residents. Watching that the food is being prepared, perhaps to give good advice is also to be active. Scent and taste of good food, wake up the appetite, increase the well-being, entice small eater to taste, wake up memories and provide good conversation topics. The movement and positioning can be stimulated through play and movement.

According to the Eden concept, a daily life must be ensured, the opportunity to have both duties and enjoyment, privacy and communities, to be outdoors and indoors, as well as having the possibility of having company of animals and children while providing the necessary and qualified care. A natural everyday rehabilitation effect is achieved because of the efforts of competent and incentive staff in a respectable, equal partnership with the residents and their families. Hope, dignity and well-being are kept.

5. The communication process in nursing homes.

The person-centered approach requires that the tasks are solved interdisciplinary. It is necessary that the management support the task of solving the tasks in the interdisciplinary team where the value base must be shared and where understanding of academic differences can be established. Interdisciplinary is supported by having offices close to each other and being easy to meet.

An exact formula for the good cross-sectoral / interdisciplinary cooperation is not found. The solutions to the challenges arise locally based on dialogue and common values. You learn by participating in community practices that facilitates through the daily work where team members collaborate, observe and talk to each other.

The condition for a development-oriented approach rather than a routine one, is that there must be time, space and framework.

Interdisciplinarity is usually associated with quality, but so far, there has been no evidence that this was the case. Recent research by the American Professor, Jody Hoffner Gittel and her colleagues, however, has shown that there is quality and efficiency associated with interdisciplinary and possibly cross-sectoral cooperation. Gittel can document that the level of relational coordination in the healthcare system has an effect on admission time, the patient's self-reported capacity and pain after surgery, the number of readmission in medical departments and the employee's job satisfaction. In her elderly care, she also documents higher job satisfaction and increased self-reported quality of life among the citizens, the higher the level of relational coordination.

Gittel defines relational coordination as coordinating of work relationships through shared goals, shared knowledge and mutual respect. The relationships contribute and are supported at the same time by the fact that communication is adequate, given at the right time and is understandable, accurate and problem solving.

There must be common goals across functions and departments. Not only the goal of one's own function / department and shared knowledge of the crosscutting work process in its entirety. Mutual respect: You must be able to see how your own and others' task solution contributes to the cross-cutting workflow and the common goal and actively coordinates with others when one's own task solution affects others in the cross-cutting workflow

When employees share goals and knowledge, they can provide better care, precisely because they have the same goals and know each other's tasks. Respecting your colleagues means trusting in their assessments. Respect helps build good relationships and good communication practices. The communication must be sufficient, not too much, not too short and it must be timely, it must be accurate and if problems arise, the focus must be on solving them. Too much information may seem like noise and is a time trial. It is also clear that the information should be timely, for example. A citizen has fallen and has broken his leg. The information cannot wait. When communication is frequent, timely, accurate and problem solving, it will again help the employee to support the common goals, share their knowledge and increase mutual respect between each other as collaborators. This is a good circle.

If each department has its own goals, highly specialized knowledge and does not adequately value their collaborators, it often results in a delayed or inaccurate communication and the organization is more keen to designate who is "guilty" , than to solve the challenges of the citizen's best. This communication is again conducive to the lack of respect, etc. That is the bad circle

At the same time, Gittel can document that the degree of communication's frequency, timing, accuracy and focus on problem solving has a significant impact on the quality of the coordination. Overall, relational coordination is to coordinate with each other in order to integrate one's own task solution with others, focusing on achieving a common goal that of course complies with the wishes of the citizen. There is evidence that when the degree of

relational coordination is increased across, it is a fundamental improvement in the work process, which increases efficiency and increases the quality of core service.

Relational coordination explicitly emphasizes the nature of communication that helps to improve the relationships in the organization and on the importance of mutual respect in collaborative relationships.

Relational coordination is particularly important for quality and productivity in work processes that are characterized by:

1. Mutual dependence between the professionals' performance of the assignment.
2. A high degree of unpredictability.
3. Work under time pressure.

These three characteristics are, to a degree, a hallmark of health care. All healthcare professionals rely on their partners so that the citizen can get the best treatment. It is not useful for the physiotherapist to come to work if the person is in the middle of his breakfast or that the assistant is standing outside the home lacking information. There is also a high degree of unpredictability. We work with people, and they do not always do what we expect or acute situations can occur that kill all plans for the day; Last but not least, everybody in the health service is subject to a fairly tight time management, home care visits many places with time indications and hospitals have accelerated patient progress.

6.The importance of the surroundings for the care of citizens with dementia (Architecture and design adapted to the elderly, disabled and technical aids)

The surroundings are of great importance to the well-being and quality of life for people with dementia.

What does the physical framework mean for people with dementia? Unfortunately, there is no single, unambiguous or short answer. Living with a dementia affects everyday life in many ways, including because they have reduced memory, impaired orientation ability, reduced initiative and ability to communicate, lack of overview and judgment and some change in behavior.

A dementia friendly environment is characterized by taking into account the disability that accompanies a dementia disease. Customized environments can support the person with dementia to do the best with the resources they have and to make everyday life as safe and secure as possible. If the environment is not adapted to the person with dementia, it may cause the person to function worse and that behavior changes inadequately

Homeliness

'Homeliness' is often described as the opposite of 'institution'. A care center must serve as a housing and as a workplace. Homeliness can be promoted by building homes in smaller units, so the physical framework does not get too big, and so that the kitchen room resembles normal single-family houses. The goal is to create a recognizable and homely environment that provides security and memories, and helps to support the individual's identity. It must be clear that people lives their lives here. Small, intelligent housing units can be helpful as people with dementia often find it hard to keep an overview of what to do and when. It is to know where you are located and what is going on in the room. The surroundings should ideally give a hint of what to do and what is expected of one.

Safety and security.

To be safe, it is required that the surroundings are predictable, understandable and recognizable, as well as focusing on routines, habits and presence. Many residents with dementia need a lot of confidence to thrive. Confidence is often achieved by being close to other people, and therefore good, spacious and centrally located common areas are important.

Orientation

It must be easy to orientate visually in the surroundings. If all is the same, it is much harder to orientate and distinguish things from each other. By maximizing color contours in the environment, it can support the residents' ability to spot the things they need to use and better assess the distance, etc. Landmarks can, be things, colors, signs or furniture that are located so it is easier to orient. People with memory problems often forget, what is out of sight. Therefore, the items / rooms / doors that the person should use should be visible to guide them. For example, it may be a great help that the toilet can be seen from the bed, that the armchair is located with a view to the hallway or in the common room things that allow meaningful activity are in sight and can be used if you should please. Other doors or exits can be made as discreet as possible.

Furniture and decor

Furniture and furnishings can help to promote homeliness and make you feel comfortable and welcome in the rooms. However, at the same time there are a number of considerations that must be taken, as people with dementia often find it difficult to accommodate many stimuli and to properly process them. Contrast furniture can make it easier to judge distances while patterned curtains or wallpaper can help to provide too many visual stimuli. Mirrors can be misinterpreted and cause turmoil for residents with dementia. Blank or lacquered surfaces on e.g. floors can be perceived as wet and thus cause uncertainty due to fear of falling. All this due to false interpretation of stimulus.

The older eye needs more light, and therefore there must be focus on lighting in the homes. Light can help lead. We often look for light, which can be used in everyday life. With the new options for adjusting the brightness and color of the light, targeted use of lighting can help support the daily rhythm and promote well-being. Dark areas in the building can create insecurity.

Outdoor Living.

It can be crucial for a person with dementia to be able to decide when you want to get out. Self-determination has an impact on all people and easy access to a safe outdoor environment can help promote self-determination. For example, it may be a closed garden with the possibility of movement, stimulation and activity. Several studies have shown that outdoor areas constitute one of the most important factors for the well-being of the residents, both physically and mentally. A sheltered outdoor environment can therefore be crucial for a good day of living.

Adapt stimuli and invite to activity.

It is important that the surroundings have obvious stimulation and activity opportunities both inside and out. There must be stimulus, and at the same time unnecessary disturbances should

be reduced. Because of dementia, the brain becomes poorer to sort in the many sensory impressions and therefore it can be difficult to keep focus. Disturbing sounds may come from TV, radio, dishwasher or people passing by. Too many stimuli and lack of employment can make the person uneasy, restless and seeking. Through visible and recognizable things, images and environments one can invite meaningful activities and thus support the person with dementia in everyday life.

Summary of unit 4

Dementia is a collective term for the state of a number of diseases, which is characterized by permanent weakening of mental functions. Alzheimers dementia is the most common, followed by vascular dementia, **Lewy Body Dementia and Frontotemporal Dementia**

Kitwood emphasizes that the person retains his value as a human being throughout the process of the disease. This implies that, that you get the opportunity to engage in relationships that you appreciate and where your, yourself are appreciated. As a human being, one needs to be valued in a community.

According to Kitwood, the person-centered approach is to see the person with dementia as an equal person with feelings, rights, wishes and a life story that has affected the person before receiving a dementia. Therefore, a person with dementia must be understood from both a biological, a psychological and a sociological perspective.

The good practice in the person-centered care must always fight the three ailments in old age.

Loneliness: Is the pain we feel when we want, but cannot share the presence with anyone.

Boredom: Is the pain we feel when we lack variation and spontaneity in everyday life

Helplessness: Is the pain we feel when we always receive care and do not get the chance give someone our care

Communication at the nursing home must be funded on be common goals across functions and departments. Not only the goal of one's own function / department and shared knowledge of the crosscutting work process in its entirety. Mutual respect: You must be able to see how your own and others' task solution contributes to the cross-cutting workflow and the common goal and actively coordinates with others when one's own task solution affects others in the cross-cutting workflow.

The surroundings are of great importance to the well-being and quality of life for people with dementia. Living with a dementia affects everyday life in many ways, including because they have reduced memory, impaired orientation ability, reduced initiative and ability to communicate, lack of overview and judgment and some change in behavior.

A dementia friendly environment is characterized by taking into account the disability that accompanies a dementia disease. Customized environments can support the person with dementia to do the best with the resources they have and to make everyday life as safe and secure as possible.

Questionnaires unit 4. Dementia

Q1. There are four types of dementia

False

Q2. People with dementia has the same needs as anyone, they just need help to get them covered

True

Q3. Communication should be sufficiently, timely and accurately

True

Q4. Good practice begins with good hygiene

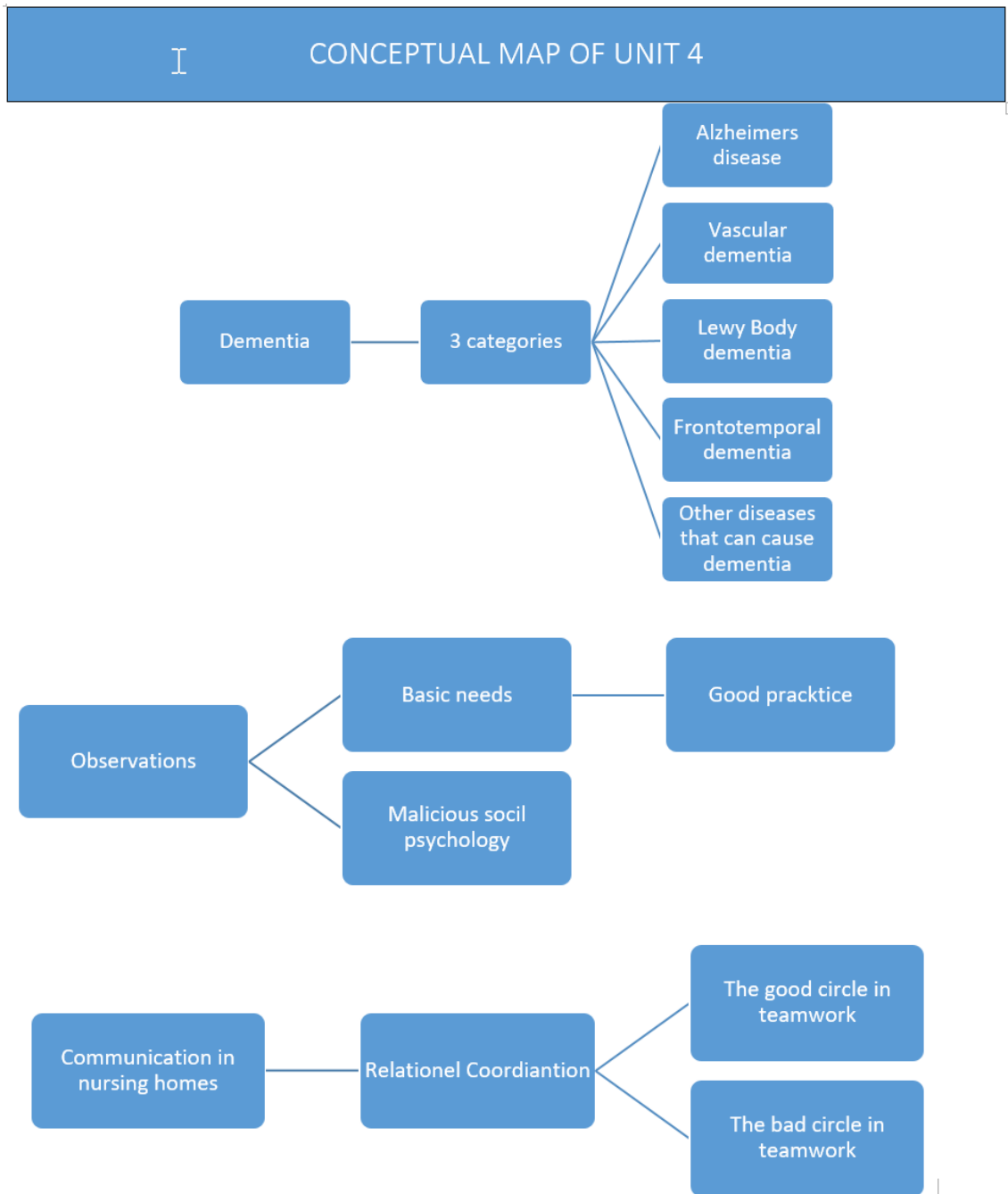
False

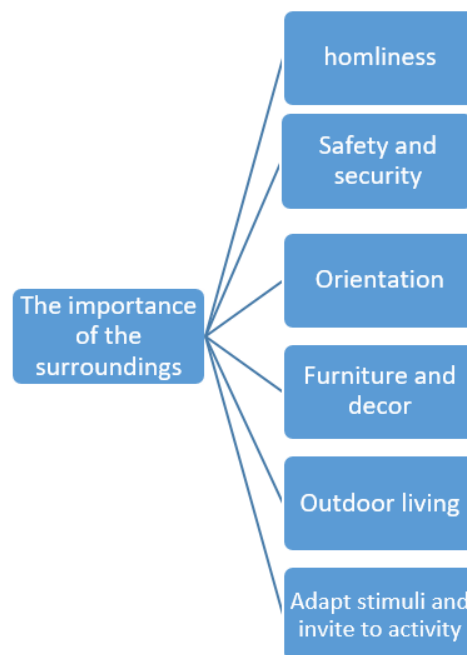
Q5. The surroundings are not important to people with dementia

False



Conceptual map of unit 4





UNIT 5. The roles of the relatives to the person in long – term care

1. Who are they?

The concept of the closest relative has emerged within gerontology and is used as the term for people who provide informal care to a person, who in this case lives in a nursing home or is in long-term care. The relative may be a family member, a friend or a neighbor. The relative has an already existing acceptance of the person who needs care as well as a relationship with them; therefore, they are essential for the citizen's social life. Participation in communities does not go without social relations - and it is this effort, the relative masters.

Previously in Denmark, it was the family's responsibility to take care of the family member, who had special needs. Eventually, society took over the responsibility, children with disabilities went to boarding schools, disabled were institutionalized and old people went to nursing homes. Through the sixties up until the nineties, it was commonly believed that people with diseases, people who were handicapped or simply old, were a task for society to take care of. That way those who were in need of help were separated from their family and their friends. After the financial crisis and repeated economic cut backs in the public sector, a new light was shed on the relatives and their resources. Once again, there was a political expectation in which relatives were expected to take care of the people who needed help.

Family structure has changed dramatically over time; at the beginning of the century, the nuclear family was almost the only type of family. According to Denmark's statistics, there are at least 37 different family constellations today – mainly due to people getting divorced. This means that a child might have to relate to eight grandparents and thus the relation may be different. A child may not feel as responsible or connected towards all eight grandparents. This results in a societal challenge, when you want to involve your relatives more in the work. There exists a general community trend, where the elderly is more and more involved in the daily work.



Central Denmark Region has amongst other publications, published a paper called "Less Patient, More Citizen". The main concern is to get the citizens and the relatives to take more responsibility.

2. How do they contribute?

In recent years, there has been a focus on what part the relatives play in order to sustain good treatment and care. In general, literature shows that the relatives are primarily responsible for social and emotional support for the citizens and that the relatives alleviate loneliness and help support the citizen's adaptation to a new everyday life. Literature suggests that there is a correlation between the facts that, the more social support the citizen experiences, the more trust the citizen seems to have in his/hers own abilities to do well at home. In addition, studies show that the relatives play a greater role in daily training and exercise for the citizens, than the professionals do. Relatives are a resource and a help and their contribution increases, the more they cooperate with the nursing staff for the benefit of the citizen. Support for families requires time and effort - especially at the beginning of a care process. However, it pays off tenfold when the result is a successful care and a safe and satisfied patient/elderly person.

The relative acts as a practical assistant by accompanying and being present, by driving, bringing and collecting. She follows what happens in the everyday life of the citizen, how the citizen is doing and feeling. Furthermore, she keeps herself informed about the citizen and keeps an eye on that he is getting the needed help as well as possibly contacting the social authorities to find out more about the citizen's situation. The relative is closely connected with the citizen, has a close emotional relationship and knew the citizen before he became depended on professional help. She knows what he likes, dislike and what he appreciates. The relative thinks of the term "we", rather than "him" and "me". The relative is the only one, besides the citizen, that knows the whole process and what has happened to the citizen when going from being able to manage everyday life at home up until he became depended on professional help. For a large number of the relatives, there are extra tasks they have to attend to. For example cleaning or administrating medication. It may be necessary to distribute the roles in the family differently when disease or progressive disorders occur. A citizen state: "Before, I managed the economy, but now my husband has to step up and learn how to calculate and I have to relax and leave things to the bank and trust that they are doing well" (female with brain injury). Some relatives are either very old, such as spouses, or they are middle aged and are still active in the labor market. In addition to having old parents they also have their own children and grandchildren to attend to.

3. How is it to be a relative?

In Denmark, the relatives have been given a far greater responsibility for their family members than earlier. Patients are discharged from the hospital earlier than before and at the same time; there are more and more people with chronic diseases in Denmark. 1.7 million Danes have one or more chronic diseases and therefore need to learn to live with their illness in their daily lives. It affects their relatives - and they increasingly seek knowledge about the patient's illness and progress. Relatives do not feel properly involved, nor do they feel like they have the opportunity

to say no. In addition, they do not have access to the right and necessary information about the disease that has affected their loved one – nor do they know their options and rights as relatives. Many relatives do not feel that they are properly informed to take care of their sick family member or friend and does not know the needs that is related to being ill. Several relatives experience the process as a struggle for the sick/old, against both the professionals and the system. They find that the staff do not take them seriously and that they are considered difficult when asking questions. On top of this, two other battles can be added: One is the struggle that specific relatives has to go through in order to be heard as relatives. This occurs if the citizen prefers one relative rather than another as the closest relatives. It could be a lover rather than the spouse. Another form of struggle that relatives experience takes place internally in the group of relatives, when their opinions differ and they cannot agree. For example, if a citizen, who cannot communicate himself, has many children, who do not agree on how their parent should be treated, then problems might occur.

The relatives experienced unwavering procedures when dealing with the citizen. They thought it had a direct or indirect influence on the cooperation and dialogue. Some of these terms can be due to procedures, habits, routines and way of thinking where logic or humanity is not always obvious to their relatives. An example can be if the doctor is only available at a certain time when the relative cannot be present or the relative visits the nursing home after work and wants to hear how the citizen is doing, but because the staff has just shifted no one knows anything.

Another topic that appears in the study is whether or not the relatives should participate in caring for their loved one. Here there are two positions. Some relatives feel compelled to attend. This is especially when the relatives are distrustful of the professional's handling of the care task. They simply believe that their dear one does not get the right care. Other relatives feel differently and may have taken responsibility for all care at home and now that the spouse has moved to a nursing home, they feel excluded and insecure and as though they are not a part of the nursing team. Both reactions could be due to lack of resources, scheduled routines, cultural thinking (e.g. an implicit professional's reluctance to allow relatives to be involved) and a lack of physical facilities. Essentially, in this context the relatives must agree that they themselves will set the limits for how they would like to participate. The relatives will help define which tasks and roles they want, which will define how they want to participate. This co-participation can contribute to developing a cooperation and dialogue between the relatives and the professionals, which they perceive as rewarding. Both Danish as well as foreign projects and studies show, that when it is possible to involve patients/citizens in the planning of the patient's/citizen's own treatment and in developing a health care system, you will achieve far better treatment results. Inclusion may for example mean fewer healthcare failures and patients/citizen taking their medication as instructed as well as them staying in a treatment that they otherwise would have ended preterm. Thus, it is possible to avoid unnecessary readmission to the hospital and they generally get better. There is a need to look at the family as a unit of mutual commitments, rather than seeing a diseased individual with potential family resources around him. There is a need for us to talk about how to distribute tasks.

It is a big problem that relatives of severely ill persons are overlooked, as they are also heavily affected by the situation of the patient's disease and therefore need information, involvement and support.

4. How are the relatives doing?

Research shows that relatives of elderly in need of care, belong to a high-risk group of getting stress, physical and mental symptoms such as depression etc.

According to international examinations, relatives see a GP 4% more often and receive more prescription drugs than the control group. Depression occurs 2-3 times more often with relatives, than in the normal population. According to a study, the majority of the relatives have sleep problems, depressive symptoms and other burdens. Relatives have less confidence in their own competencies (self-efficacy) and inferior overall subjective well-being. Furthermore, they are at greater risk of developing a serious disease, such as cardiovascular disease. Age, health, gender, socioeconomic status, social support, coping strategies and family relationship to the affected person, and qualify hereof, may affect the strain of the relatives. For example, it is well known that the load is greater the older the relative is. This can be explained by the fact that older relatives themselves experience a deterioration of their physical, mental and social functioning and that the care situation is likely to affect them in a negative way. With regard to gender, studies have shown that men and women respond differently to a care situation. Male relatives develop more diseases that are physical, while women have a higher risk of psychological symptoms such as loneliness and depression. Furthermore, a link between low education and lower levels of burden for men is identified. A possible explanation is that men apparently are influenced by the care burden to a lesser degree than women and the two sexes have different coping strategies.

Several studies indicate that the relative's choice of coping strategies has a major impact on the care burden. The relatives who combine acceptance with the appropriate problem solving strategies experience a lesser burden.

In general, it is not sufficiently examined whether certain factors add to the care burden or consequence of the care situation. Depression may, for example, contribute to the care burden or be caused by it. A Belgian national study concludes that it is not the objective scope, but most of all factors in relation to the relatives themselves, that are decisive for the effect of the care situation on the relatives.

Statistics Denmark has made a survey in 2015 for DaneAge Association about relatives. It included interviews with 920 adults aged 18-64, all of whom are children of home care citizens over 64 years. It appears that the majority of the relatives are still active on the labor market (68% of the interviewed). This means that they must manage to work, have a family and take care of the elderly relative. This however, the survey showed to be difficult:

36% find that it affects them to help their relatives. One in ten of the relatives in the survey has decreased their working hours in order to take care of their loved one.

About a third has said no to new challenges at work for the same reason.

One in five even indicates that they have lost income due to care tasks.

Nearly half have experienced problems concentrating at work due to the care task.

23 % of respondents have become physically ill because of helping a close relative.

When relatives become sick themselves due to helping their relatives, society risks having to help two people instead of one.



How does the relatives take care of themselves?

As a relative, you find yourself in a completely new and perhaps unexpected situation. Some people might be unsure of the situation and may find it difficult to handle the thoughts and feelings that suddenly appear. Others find it difficult to talk about their own feelings and frustrations in the family, because the focus is on the person that needs care. There is, as such, nothing wrong with it. However, it means that you as a relative can find it hard to find room to talk about the things that burden you. As a relative, it can be difficult to focus on yourself and your concerns, but it is important to stay positive, because if not you cannot support the person who needs care nor keep yourself up. Everyone has limits to how much they can handle and different ways to react when they encounter difficult experiences. That is how it is and there are no right or wrong way to be a relative.

Many relatives experience symptoms of the daily tasks has become too much. They can occur during a course of disease or as a post-reaction. Fatigue, difficulty concentrating, sleep disturbances or other reactions may be due to stress or depression. These are serious signs that relatives should not be afraid to seek help.

Therefore, it is important that the relative have someone who will listen and talk to her. It may be someone in the family or a friend who is particularly close. Some citizens prefer to talk to an impartial person such as ones GP, a nurse at the hospital, a psychologist or another professional with a particular knowledge and understanding of the situation. The most important thing is that the relative chooses a person who he or she feels safe talking to about his/hers thoughts and feelings. In Denmark, associations for relatives exists, where you can talk to others who are in a similar situation. Here you can talk about problems and feelings you have and get the opportunity to share experiences and good ideas with other relatives. Peer-learning networks can be a volunteer network, a network of the patient and relative's association or in a local municipality context.

Relatives of citizens with dementia

Are they different from other relatives who are caregivers? The majority (73%) of the relatives, who help people with dementia are over 65 years old and must provide greater care than relatives of citizens with other chronic diseases must. An examination of 469 members conducted by the Alzheimer's association from 2011 showed, that relatives of people with dementia in Denmark spend about six hours a day on average on care and supervision of their spouse or cohabiting partner. They are not a homogeneous group and the care burden is relative and depends largely on factors relative to the person with dementia and most of all the relatives. The care burden and the increased physical and mental burden can weaken the health of the individual relative.

Being a relative of a person with dementia may be associated with a significant and prolonged psychosocial strain, which can result in deterioration of health, social isolation, anxiety, depression, sadness, etc. Relatives of citizens with dementia feel more stressed and take more medication than other relatives take.

There are also more family conflicts and social isolation, as their relatives downgrade their own network and give up on holidays or maintaining their interests.

The relatives may experience "losing" a person they care for and often feel an increased responsibility towards the person with dementia.

Both are exposed to a great emotional burden, as well as great practical, legal and social problems following dementia, also in the early stages.

In addition, it seems that children of parents with dementia does not appear to experience negative effects due to the care situation as much as the person with dementia's spouse. This is probably due to the age and the relationship with the person with dementia - the closer the relationship, the heavier the care burden. Another reason may be that children have the opportunity to choose the role of primary care provider, whereas the spouses does not. In addition, children are more often active on the labor market, which creates a better opportunity to break free and enjoy freedom from the care role. The handling of and the burden due to the care situation depends on the quality of the child-parent relationship before the illness occurred.

As a relative, you have to deal with both your own losses in relation to the person with dementia, but also in terms of seeing the person disappearing more and more, often over years and they take increasingly responsibility for another adult. The relatives and their spouse lose their shared history, they must constantly adapt and get used to the role of being the closets relative. It is in some ways comparable to other progressive disorders, however not completely. The dementia's prerequisite for being present and being present for a longer period, fades in the progresses of dementia. It places special demands on relatives and professional caregivers.

Politically, there has been an increased focus on citizens with dementia and their relatives. In January 2017, the Ministry of Health and Public Affairs published "A safe and worthy life with dementia, National Dementia - Action Plan 2025". The ministry states that in all parts of the country, people with dementia and their relatives must meet a high level of professional quality, based on dignity, compassion and respect for the individual's wishes, needs and resources, and for the human behind the disease and his/hers lived life. The National Dementia Action Plan 2017-2025 sets out three national targets for dementia efforts by 2025, supported by a wide range of concrete initiatives across five focus areas.

1. Denmark must have 98 dementia friendly municipalities.
2. More people with dementia must be examined and 80 per cent must have a specific diagnosis.
3. Improved care and treatment efforts should reduce the consumption of antipsychotic medicine among people with dementia by 50 per cent by the year 2025.

Below are five focus areas:

1. Early detection and better quality in examination and treatment
2. Better quality in care, nursing and rehabilitation
3. Support for people with dementia and their relatives
4. Dementia friendly homes and communities
5. Increased knowledge and skill level

Included in the focus areas, 23 different initiatives have been identified and the following points are mentioned under focus area three:

- Development and dissemination of a national toolbox with patient and relative courses



- A higher number of meaningful day care services as well as support for younger people with dementia
- Advisory and activity centers for people with dementia and their relatives including younger people with dementia.

Summary of unit 5

The relative may be a family member, a friend or a neighbor. The relative has an already existing acceptance of the person who needs care as well as a relationship with them; therefore, they are essential for the citizen's social life.

Relatives do not feel properly involved, nor do they feel like they have the opportunity to say no. In addition, they do not have access to the right and necessary information about the disease that has affected their loved one – nor do they know their options and rights as relatives. Many relatives do not feel that they are properly informed to take care of their sick family member or friend and does not know the needs that is related to being ill.

According to international examinations, relatives see a GP 4% more often and receive more prescription drugs than the control group. Depression occurs 2-3 times more often with relatives, than in the normal population. According to a study, the majority of the relatives have sleep problems, depressive symptoms and other burdens.

As a relative, it can be difficult to focus on yourself and your concerns, but it is important to stay positive, because if not you cannot support the person who needs care nor keep yourself up. Everyone has limits to how much they can handle and different ways to react when they encounter difficult experiences. That is how it is and there are no right or wrong way to be a relative.

Being a relative of a person with dementia may be associated with a significant and prolonged psychosocial strain, which can result in deterioration of health, social isolation, anxiety, depression, sadness, etc. Relatives of citizens with dementia feel more stressed and take more medication than other relatives take.

Questionnaires u5. The relatives.

Q1. The relatives helps with medication

False

Q2. Relatives have a higher risk at getting depressions

True

Q3. It is difficult to take care of your relatives

True

Q4. The relatives feel that they get good information

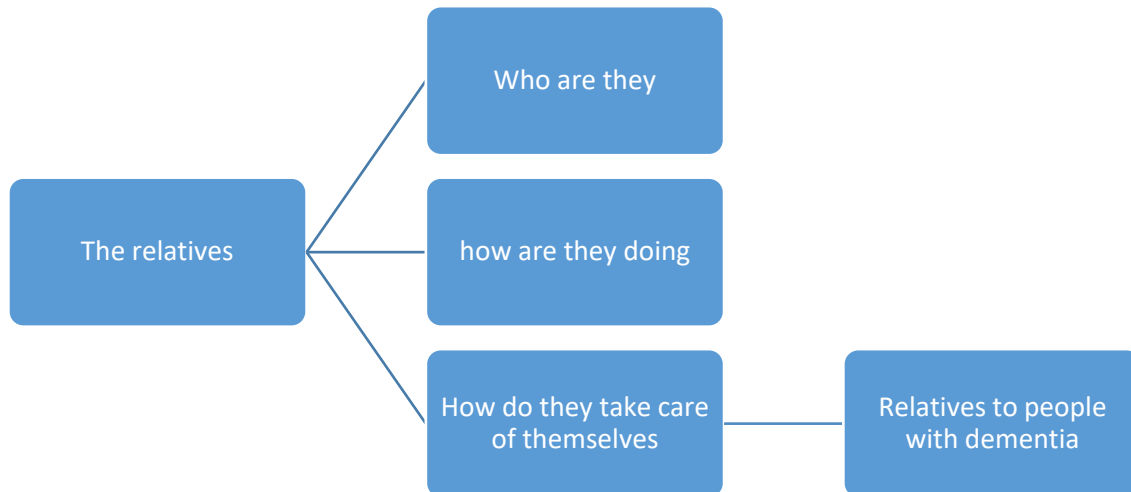
False

Q5. Relatives to people with dementia iare more stressed than the average relative

True



CONCEPTUAL MAP OF UNIT 5



UNIT 6. Professionals in home care and at nursing homes

The professional's profile

What does it take to become a good care giver, who can work within the framework given and who always puts the citizen in need of help first. In Denmark, we have a tradition of hiring social and healthcare carers, assistants and nurses to take care of the weak citizens. Hence, we will go through the two educations the school offers.

1. The Social and health care helper education

Ministry of Education and Research describes the social and health carer education as follows: Through the education, you will learn to help and support the elder in such a way that the elder can lead as good an everyday as possible on their own. You will support the elder in creating a good structure of everyday life. Among other things, you will help with personal hygiene, with domestic tasks such as cleaning and laundry and with activities, which increases the elder's well-being. At the school, you will learn about health and well-being and about nutrition and exercise, so you can guide the elder. You will gain knowledge about the body, the most common diseases and about how you can prevent them. As a social and health carer, you will also become able to communicate better and work together with the elderly and their next of kin.

The education for Social and health care helper

To be able to take on the described tasks, it is necessary that the person have the right education. In order to get an insight into what is being taught through the education, in order to gain the competences needed, the education will be explained here. The education is a mix between school and practical work. It begins with a basic training course.

Social- og sundhedshjælper: 2 år og 2 måneder



Fig. The structure of the social and health care helper education: Basic course (green), school (blue) and internship (light blue). Total duration; 2 years and 2 months

At the school, the following topics are mandatory:

The role of the social and health carer:

- Being with the citizen
- Personal help, nursing and care
- Health promotion, prevention and rehabilitation
- and there is a list of optional topics:
 - The cooperation between the citizen suffering from dementia and his/hers next of kin
 - Diet and exercise for vulnerable groups
 - Quality of life and prevention of loneliness
 - Meeting citizens with mental illnesses
 - The social and health carer's tasks through the palliative course
 - Well-fare technology and tasks involving tele medicine

Through the internship in a nursing home and in the home care, the students learn the work tasks that comes with the education. After the basic training course, the local authority hires the students. Through the practical internship, the students have an internship supervisor, who will help them reach the described goals for the internship. The goals for the full education of the practical internships are as follows:

1. The student can professionally and independently take care of personal nursing and care as well as take care of personal and practical help in order for the citizen to maintain his/hers possibility of self-expression and quality of life.
2. The student can, in regard to the right of self-determination, motivate the citizen to actively take part in their rehabilitations course, in order for their self-care, well-being and practical functional capacity is kept as much as possible through everyday life.
3. The student can work with a focus on health-promotion and prevention, and act appropriately at changes in the citizen's physical, mental and social health care condition.



4. The student can, in regard to lifestyle and conditions of life, independently motivate and support the citizen in terms of health-promotion and prevention as well as inform the citizen of relevant private and local offers – among these contact to networks and voluntary people.
5. The student can, from a professional view and the recommendations from the Danish Health and Medicines Authority for early detection, local procedures and rules, initiate actions independently. Amongst this, screenings relevant for the citizen's everyday life.
6. On basis of the citizen's state of nutrition, the student can initiate relevant actions that focus on the citizen's diet and nutrition as well as the importance of a meal.
7. The student can independently support, guide, initiate and evaluate physical, cultural, creative and social activities together with the citizen in order to support the citizen in managing his/hers own life.
8. The student can independently inform and support the use of digital aids with a focus on training and practical help.
9. The student can professionally document the planned and accomplished effort of the care- and training agendas in agreement with the workplace's guidelines and use electronic document systems.
10. The student can establish a goal-oriented communication, accomplish and conclude the professional meeting with the citizen and the relatives as well as include relevant work partners.
11. The student can meet other people in an ethical, empathic and respectful manner as well as reflect over and give reason for his/hers own professional role in the process of human-to-human relations.
12. The student can handle conflicts and work to prevent violence in line with the guidelines for the work environment.
13. The student can independently relocate a citizen in agreement with the ergonomic principles and can independently apply and maintain aid facilities and relevant well-fare technology.
14. The student can independently apply personal hygienic principles as well as contribute to the prevention of diseases spreading in line with national and local guidelines and guide citizens and relatives about this.
15. The student can plan and carry out different tasks, which are understood and regulated by the Social Service Act and the Danish Health Act as well as the internships' practice for delegating assignments.
16. The student must work independently within his/hers area of competencies and in line with local quality standards for unintended incidents etc., and be part of co-operation with relevant colleagues and interdisciplinary collaborators.

The objectives for the education is as follows:

The role of the social- and healthcare helper



1. The student must apply knowledge about the structure and legislation of the social and health services, such as confidentiality, access to documents and consent to take care of the social and healthcare helper's field of work.
2. The student may apply knowledge about the Service Act and the Health Act, including rules for delegation, as a framework for social and health care services to select and carry out tasks within their own areas of competence.
3. The student can apply knowledge about legislation and local guidelines for unintended incidents to participate and take co-responsibility for quality development of practice.
4. The student can apply knowledge about social and health policy objectives, health agreements and visitation systems to reflect on the care of the work as a social and healthcare helper.
5. The student can apply knowledge of locally established quality standards, performance catalogues and service levels to prioritize tasks in relation to the citizen's needs and functional level.
6. The student can apply knowledge about the organization of the workplace and the opportunity for employee involvement to independently take co-responsibility for well-being at the workplace.
7. As a professional and authority figure, the student can apply knowledge about the importance of cross-sectorial and interdisciplinary cooperation, including documentation and dissemination of professional information to create structure and coherent development for the citizen.
8. The student can apply knowledge of relevant business partners' work areas to make relevant observations of the citizen before consulting other professionals.

Meeting with the citizen

1. The student can apply knowledge of human opinions and ethics to reflect on ethical dilemmas in the professional care.
2. In the encounter with the citizen, the student can apply knowledge about own and others' culture, including the importance of life stories, in collaborating with the citizen to support a meaningful everyday life.
3. The student can apply knowledge of interpersonal relationships, communication, equality and empathy to independently plan and conduct the professional conversation with the citizen and relatives.
4. The student can apply knowledge about communication, cooperation and conflict management in the meeting with the citizen to independently contribute to the development of a good mental healthcare environment.
5. The student can apply knowledge about rehabilitation in everyday life to be able to involve and work supportively in cooperation with the citizen and relatives.
6. The student can apply professional oral and written language to convey and document observations with the citizen.
7. The student can apply knowledge about basic needs, observation methods and assessment of physical, mental and social health to motivate and guide the citizen for self-care.



8. The student can apply knowledge about how to use tools to prevent outward behaviour and display power to explain and work with respect and dignity in the care of the citizen, including citizens with dementia.

Personal help, nursing and care

1. The student can apply knowledge of the human's basic needs and level of functioning, in cooperation with the citizen, to plan, perform and evaluate care and nursing tasks that promote the citizen's self-care.
2. The student can apply knowledge about hygienic principles and procedures for food management change of bed linen, sorting of laundry and cleaning in order to independently prevent spread of infection and discontinue routes of infection as well as independently perform practical tasks at home.
3. Students can apply knowledge about hygienic principles, interruption of infection paths, personal hygiene procedures, oral and dental care and medication as a delegated task, to independently carry out care and care tasks with the citizen.
4. The student can apply knowledge about cooperation in the rehabilitative effort to involve and activate the citizen in the prioritization and execution of practical and personal help.
5. The student can apply knowledge about the function level, needs and most affected chronic diseases for aging citizens in order to plan, perform and evaluate personal hygiene and care tasks with care and respect for the individual.
6. Based on the National Board of Health's Early Detection Tools, the student can apply knowledge about the principles of observing the general health of the citizen in order to respond appropriately to this, including conducting documentation and contacting relevant professionals.
7. The student can apply knowledge about the body's structure and function, including the physical and mental aging process, in order to observe and identify typical symptoms of altered behaviour as well as initiate relevant actions.
8. The student can apply knowledge about digital tools to guide and support the elderly in accessing the digital system in Denmark.
9. The student can apply knowledge about the most common dementia diseases, their causes, symptoms and development to explain the importance of dementia for the citizen's everyday life.
10. The student can apply knowledge about the potential symptoms of the elderly citizen in conditions such as cystitis, pain, fluid shortage and development of deliries in order to organize and perform care and support for the citizen.
11. Retrieval of first aid in vocational education, according to the Danish First Aid Council's education plans per. August 1, 2016.

Health promotion, prevention and rehabilitation



1. The student can apply knowledge about the rehabilitative approach to involving the citizen, taking into account his/her ability to function, in the choice and planning of activities that promote the citizen's quality of life and competency.
2. The student can apply knowledge about cooperation and citizen involvement in order to support the citizen's self-determination in his own life.
3. The student can apply knowledge about normal aging and lifestyle diseases to work preventively as well as guide the citizen in healthy choices.
4. The student can apply knowledge about nutritional diet, food and meal meaning, in collaboration with the citizen and relatives to initiate preventive and health-promoting measures and ensure suitable nutrition.
5. The student can apply knowledge about local prevention packages to inform and guide the citizen regarding the choice and use of relevant offers.
6. The student can apply knowledge about involvement of relatives and volunteers in order to collaborate to organize intellectual, social, cultural, physical and creative activities based on a rehabilitative approach.
7. The student can apply knowledge about care plans and training plans to work targeted at the citizen's rehabilitation process from a holistic perspective.
8. The student can apply knowledge about the importance of network for the citizen to be able to cope with the rehabilitation course and can support the citizen in networking, including using opportunities for support in the voluntary networks.
9. The student can apply knowledge about forms of communication that can motivate the citizen for self-care in preventive and rehabilitative work.
10. The student can apply knowledge about work environment and ergonomics to independently plan and execute relocation tasks, including preventing workloads and occupational accidents using welfare technology, aids and ergonomic techniques.
11. The student can apply knowledge about welfare technology to guide the citizen in the use of technology that can support the citizen's ability to function and manage everyday life.

2. The social and health care assistant education

The Ministry of Education describes the education as follows: Through the education, you gain basic knowledge of providing practical and personal help. Furthermore, you also learn about nursing and care tasks and about how to plan activities that strengthens the health and prevents illnesses. At the school, you will among other things learn about the body, the most common diseases and the connection between lifestyle and disease. You gain knowledge about hygiene, prevention of infection and about chemistry in, for example, care products and medicine. In addition, you learn how to administer medicine to the citizen and to document the nursing you are performing. You must be able to communicate well and work with citizens, patients and relatives. You will also learn how to work with other health professionals and how to organize a coherent care program.

As a social and health assistant, you perform nursing tasks, plan activities and guide social workers in home care, nursing homes etc.

<https://www.ug.dk/uddannelser/erhvervsuddannelser/omsorgsundhedogpaedagogik/social-og-sundhedshjaelper>

^ Uddannelsens opbygning

Social- og sundhedsassistent: 3 år og 10 måneder



● Grundforløb ● Skole ● Praktik

Fig. The structure of the social and health care assistant education. Basic course (green), school (blue) and internship (light blue). Total duration; 3 years and 10 months.

The education includes a basic training course, which takes place at a vocational school and lasts 20 or 40 weeks as well as a main course, which is structured as a mix between periods of internships and theoretical schooling.

At the school, the following courses are mandatory:

- Cooperation with the citizen and the patient
- The coherent citizen- and patient care
- Quality and development
- Illnesses and nurse care (both physical and mental diseases)
- Health promotion, prevention and rehabilitation
- Pharmacology and medicine management

- and there is a list of optional topics

- Social- and healthcare assistant as team leader
- Network and co-creation with vulnerable groups
- The citizen's need for acute social-psychiatric treatment
- Pain relief in relation to physical and/or mental diseases
- The social- and healthcare assistant's role at hospital admission for citizen's with dementia
- The citizen suffering from physical and/or a mental disability
- In depth nurse knowledge and professional development
- The social- and healthcare assistant's tasks in terms of the end of life

The internship is meant as giving the students the possibility to obtain vocational competencies in a professional community through execution and reflection of the daily work tasks within the professional field. The goal for the internship follows below. They are meant as end-goals and has to be approved by the end of the education.

Objectives of the internship:

1. The student can implement and reflect on clinical nursing actions, including independently using the nursing process to collect data, identify, analyse, plan, perform and evaluate nursing/patients with basic needs.
2. The student can plan and initiate health care actions based on professional and clinical assessments, including the Health Board's early detection tools, and local procedures and guidelines.
3. The student can independently identify and respond to change in the health of the citizen/patient. In case of unforeseen and complex issues, the student can perform nursing actions within his/her own field of competence and delegated nursing activities, including performing palliative care.
4. The student can assume a holistic approach that supports the citizen's/patient's coping of his or her own life independently and in cooperation with the citizen/patient and relatives work with rehabilitation.
5. The student can work independently and interdisciplinary with health promotion and, from a holistic viewpoint, prevent the development of lifestyle diseases by guiding and motivating the citizen/patient to master their own lives.
6. From a rehabilitative approach, the student can independently plan, perform and evaluate care, practical help and personal care for citizens with physical, mental and social needs.
7. The student can independently organize and carry out physical, social, cultural and creative activities, and inform and advise on activities, including network and volunteers based on the citizen's interests and needs, and support citizens/patients in making their own choices.
8. The student can independently prevent infection by national and local guidelines and hygiene standards, including special regimes and techniques, as well as advise citizens, patients, relatives, colleagues and volunteers about this.
9. The student can independently take care of medication management in line with the internship's guidelines, observe the effects/side effects and document and cooperate with the citizen/patient in the medical treatment.
10. The student can establish relationships that create cooperation with citizens/patients, relatives and volunteers, including goal-oriented communication and using relevant communication methods.
11. The student can independently conduct pedagogical activities and guide colleagues.
12. The student can communicate in a way that, taking into account their own and others' security supports the integrity and self-determination of citizens and patients in conflict management and violence prevention.
13. The student can independently communicate and document professional actions in relevant documentation systems to support patient-safe transitions and continuity in the overall citizen/patient course and increase the quality of the citizen/patient.
14. The student can independently coordinate and organize their own and others' work as well as support and participate in teamwork around task solving with the need of the citizen/patient as goal.



15. The student can coordinate and participate in the collaboration on the needs of a citizen/patient for inter-professional and cross-sectorial activities, including self-initiation, completion and documentation of social and health care services in connection with reception, admission, discharging and homecoming of the citizen.
16. The student can independently carry out citizen care using technology and guidelines based on experience-based knowledge and evidence.
17. The student can support the development of good practice for quality assurance and patient safety in inter-professional cooperation.
18. The student can relate critically to and support the development of a good physical and mental working environment, including performing relocations as well as assessing space conditions in compliance with the occupational health and safety rules and the application of welfare technology.
19. The student can reflect on and make qualified choices in relation to ethical and professional dilemmas that follow working as a professional health carer, such as confidentiality, use of power, patient rights, duty of care and consideration for the quality of life of the citizen/patient.
20. The student can plan and explain his or her own work and competence as an authorized healthcare professional in accordance with relevant legislation and others' areas of competence.

The education's objectives are as follows: Cooperation with the citizen and the patient

1. The student can apply knowledge about counselling, guidance and instruction to independently establish relationships and create cooperation with the citizen/patient about the course.
2. Students can apply knowledge about different types of goal-oriented communication to establish a professional relationship in the meeting with the citizen/patient and relatives.
3. The student can apply knowledge about different cultures and health views to meet the citizen/patient and relatives with respect for dignity and integrity.
4. The student can apply knowledge about different forms of life, life stages and life stories to take on a holistic approach in the meeting with the citizen/patient.
5. The student can apply knowledge about health education theory and method of organizing activities that support the citizen/patient's resources as well as promote rehabilitation processes and the citizen's health.
6. Students can apply knowledge about communication and the importance of equal relationships to reflect on ethical dilemmas and act empathically in the meeting with the citizen/patient and relatives.
7. The student can apply knowledge about coping strategies and motivation factors to support the citizen/patient's coping with own illness and rehabilitation process.
8. The student can apply knowledge of health education theory and method of planning and implementing information, instruction and guidance of citizens/patients and relatives in interdisciplinary cooperation.



9. The student can apply knowledge about physical and mental impairments to independently take responsibility for conflict management as well as the prevention of conflicts and power use in meeting with the citizen/patient.

The coherent citizen- and patient course

1. The student can apply knowledge about the Service Act, the Health Act and the Psychiatry Act to work in the inter-sectorial and inter-professional cooperation with regard to patient safety.
2. The student can apply knowledge about the Authorization Act and Guidance on the use of assisted healthcare professionals to reflect on and take care of the duties of social and healthcare assistants, including delegated tasks, in inter-professional co-operation on the coherent citizen/patient course.
3. The student can apply knowledge of oral and written communication to independently document and exchange data in inter-professional and cross-sectorial cooperation.
4. The student can apply knowledge about communication and guidance methods to independently inform, guide and instruct colleagues.
5. The student can apply knowledge about the Working Environment Act and the organization of the workplace to take the initiative to develop the physical and mental well-being, including the care and coordination of work tasks.
6. The student can apply knowledge about the importance of cultural understanding, values and forms of cooperation to establish and manage cross-sectorial and inter-professional co-operation.
7. The student can apply knowledge about the social and healthcare assistant's field of competence and the organization of the workplace to coordinate his/her own and others' work in the coherent citizen/patient course, including team management and coordinator function.
8. The student can apply knowledge about general practice's offer, responsibility and function area to collaborate on co-ordination of the coherent citizen/patient course.

Quality and development

1. The student can apply knowledge about the Service Act, the Health Act and the Psychiatry Act to work in the inter-sectorial and inter-professional cooperation with regard to patient safety.
2. The student can apply knowledge about the Authorization Act and Guidance on the use of assisted healthcare professionals to reflect on and take care of the duties of social and healthcare assistants, including delegated tasks, in the cross-professional cooperation around the coherent citizen/patient course.
3. The student can apply knowledge of oral and written communication to independently document and exchange data in inter-professional and cross-sectorial cooperation.
4. The student can apply knowledge of communication and guidance methods to independently inform, guide and instruct colleagues.



5. The student can apply knowledge about the Working Environment Act and the organization of the workplace to take the initiative to develop the physical and mental well-being, including the care and coordination of work tasks.
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8. The student can apply knowledge about general practice's offer, responsibility and function area to collaborate on co-ordination of the coherent citizen/patient course.

Somatic diseases and nursing

1. The student can apply knowledge about nursing theory and methodology to assess the resource, needs and health of the citizen/patient as well as to address the complexity of basic needs, including involving relevant collaborators.
2. The student can apply knowledge about the body's anatomy and physiology as well as connections between organ systems to explain and understand the importance of the organs and organ systems in performing nursing activities.
3. The student can apply knowledge about the principles of the nursing process in a goal-oriented manner, prioritize, organize, perform and evaluate clinical nursing based on the citizen's/patient's resources as well as physical, mental and social needs.
4. The student can apply knowledge about the most common diseases to explain causes, symptoms and therapies for self-care nursing based on identified needs.
5. The student can apply knowledge of somatic disease to observe changes in the citizen's/patient's health, such as changes due to dehydration, malnutrition, anaemia, oedema, respiratory problems, constipation, diarrhoea, fever, confusion, medication errors and immobility, and act appropriately this end.
6. The student can apply knowledge about somatic disease education, including multiple diseases and acute diseases, to be able to participate in complex nursing and treatment courses in inter-professional cooperation.
7. The student can apply knowledge about palliative action and terminal procedures to provide care and professional care for the citizen/patient and relatives in mourning and crisis management.
8. The student may apply knowledge of hygiene principles to work with special regimes for infectious diseases and institutional infections as well as to guide the citizen/patient, relatives and colleagues in complying with hygienic principles to stop infection pathways.
9. The student can apply knowledge about sterile routines, techniques and clean procedures to stop infection pathways and dealing with nursing tasks in connection with, for example, wounds, probes and catheters.
10. The student can apply pre- and postoperative knowledge to prepare the patient for surgery and to observe and care for the patient in the post-operative phase.



11. The student can apply knowledge of welfare technology in the nursing industry to assist in implementing new technological solutions in relation to the citizen/patient and relatives, including telemedicine solutions.
12. Acquisition of First Aid in VET after the Danish First Aid Council's education plans per. August 1st, 2016.

Mental illness and nursing

1. The student can apply knowledge about the most common mental illnesses and their symptoms including dementia, schizophrenia, affective disorders, anxiety disorders, personality disorders and double diagnoses in order to independently care for the citizens/patients with mental illness.
2. The student can apply knowledge about nursing theory, methodology and assessment, including first hand nursing, cognitive approach and environmental therapy to work as a contact person and support the citizen/patient's rehabilitation process and recovery.
3. Students can apply knowledge about interpersonal relationships and interactions as well as goal-oriented communication to establish, maintain and terminate professional relationships in collaboration with the citizen/patient with mental illness, relatives and other collaborators, including psychoquenchment.
4. The student can apply knowledge about coping strategies and the psychosocial conditions and development opportunities of the individual to independently engage in an in-depth collaboration with the citizen/patient on a nursing course.
5. The student can apply knowledge about the principles of the nursing process to the purpose of prioritizing, organizing, performing and evaluating psychiatric nursing based on the citizen's/patient's resources and needs.
6. The student can apply knowledge about complex nursing and treatment courses, including double diagnoses, multiple diseases and abuse issues, to participate in the holistic organization of interdisciplinary and cross-professional care.
7. The student can apply knowledge about social psychology and the importance of the environment for mentally ill people, including dementia, to maintain respect and dignity for the individual citizen/patient as well as prevent outward behaviour and use of force.
8. The student can apply knowledge about social pedagogical practice, such as reminiscence, sensory stimulation, person-centred care and physical activity to support a meaningful everyday life for the citizen/patient.

Health promotion, prevention and rehabilitation

1. The student can apply knowledge about health promotion, prevention and rehabilitation to take care of the role of social and health assistant in interdisciplinary and cross-sectorial actions based on the wishes and needs of the citizen/patient.
2. The student can apply knowledge about health education and lifestyle factors in collaborative collaboration with the citizen/patient and relatives to work motivating in relation to the citizen's/patient's formulation of expectations and goals for everyday life.



3. The student can apply knowledge about rehabilitation in everyday life to engage in an in-depth collaboration with the citizen/patient and his/her network, including supporting coherence in the everyday life of the citizen/patient.
4. The student can apply knowledge about clinical assessments and screening tools to make relevant academic assessments in the interdisciplinary preventive action in relation to the health and safety of the individual citizen/patient.
5. The student can apply knowledge about the importance of prophylaxis in relation to health and quality of life to cooperate with the citizen/patient about the need for physical activity and appropriate nutrition.
6. The student can apply knowledge about functional ability and function screening to select, organize and implement activities that support the citizen/patient's coping with and quality of life.
7. The student can apply knowledge about training and action plans to participate in interdisciplinary collaboration that supports the overall rehabilitation process of the citizen/patient.
8. The student can apply knowledge about the analysis, planning, execution and evaluation of social, physical, cultural and creative activities for individuals and groups to support a meaningful daily life for the citizen/patient based on a rehabilitative approach.
9. The student can apply knowledge about municipal offers, voluntary organizations and networking groups to select and carry out meaningful activities in collaboration with the citizen/patient.
10. The student can apply knowledge about functional ability, relocation, bedding, mobilization, and aids and welfare technology to organize care and care tasks focusing on the ability of the citizen/patient.

Pharmacology and medicine management

1. The student can apply knowledge about legislation, instructions, guidelines and local procedures to explain the responsibility and competence of the social and healthcare assistant to independently manage medicine management in current practices, including delegation, management responsibilities and accreditation.
2. The student can independently apply knowledge about quality assurance and unintended incidents (UTA) in an interdisciplinary cooperation to promote patient safety and prevent failure in medicine management in practice, including documenting, reporting and following up on the medical officer.
3. The student can apply knowledge of anatomy and physiology to explain the pharmacokinetics of medicine, including absorption, distribution and elimination and pharmacodynamics.
4. The student can apply medicine calculations to promote patient safety and prevent medicine managing errors.
5. The student can apply knowledge of general and special pharmacology, including psychoactive drugs, to observe effects and side effects, as well as explain contraindications, interactions and forms of dispensation within the most common main groups, including the importance of observing citizens and patients.



6. The student can apply knowledge about health education methods, tools and practices, including guidance, motivation and self-administration in cooperation with citizens, patients and relatives in the primary and secondary sectors, including collaboration with general practice to increase quality and patient safety in medicine management.

7. The student can apply knowledge about hygiene and risk factors in medication management, including the work environment committee's work and work environment certification to prevent work injury in practice.

3. Teamwork in daily life

The formation of teams is becoming an increasing way of organizing work in the healthcare system, where larger divisional units are formed, which involves the need to divide the staff into smaller groups. Some teams are mono professional others are interdisciplinary. In home care and nursing homes, team organization is the most common.

Definition of team:

A team is a group that has developed common visions and goal together as well as solving specific tasks in the way the group agrees.

It can also be described as a communicative system that evolves over time into a practice fellowship. Becoming a team requires the group to work together on specific tasks and jointly develop common goals, norms and routines.

(” Tværfaglig praksis” Eva Just og Merete Nordentoft, Hans Reitzels forlag, 2012)

Most team formation processes are the same no matter who is included in them. Research has shown that well-functioning teams provide higher efficiency, for example by to increasing the satisfaction of citizens, strengthen patient safety and reduce mortality.

Through their composition, a team has improved options for solving tasks by involving individual members of the process. Through its resources, the team can solve tasks that cross professional and educational boundaries. It provides a much better utilization of the soft, professional and hard skills of the team. Work wise; there is a greater flexibility that allows room for changing tasks and conversions between the individual tasks that allows the team and individual team member to develop their skills. It gives the individual and the team a greater content in everyday life and motivation in the changing tasks.

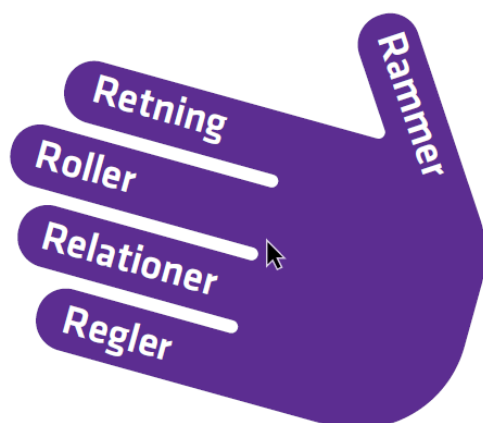
By team formation, by reorganizing teams for new tasks or evaluating the team, the following method can be used.

The Hand:

"When the team thrives. Potentials and problems in team work in the educational sector"

Published by Branche Fællesskabet for Arbejdsmiljø for Velfærd og Offentlig Administration

Arbejdsmiljøsekretariatet, oktober 2015



FRAMES ("Rammer"): What resource, physical and organizational framework do we work within? Which deadlines do we have? How much time is allocated

for teamwork?

The frame finger is important in order to get a realistic common picture of the fixed terms and conditions for the teamwork and which frames the team itself can help to expand or influence.

DIRECTION ("Retning"): What direction should we go, and do we agree where it leads us? How do we ensure that we are all going in the same direction - and what do we do, the day we discover *that don't*?

The directional finger helps you focus on goals and results. Be aware that there can be more goals and goals can change along the way.

ROLES ("Roller"): How do we distribute roles between us? How do we ensure that all roles are occupied? What requirements do we make for each other in the roles we assume? What special expectations are there for the role of team leader or coordinator?

The role finger helps you to master what you expect from each other and how to best make your differences a force for the team.

RELATIONS ("Relationer"): How do we want the social and working relationships to develop between us? What can we do for it to happen? What should we avoid? What experiences do we have from previous processes that can benefit us now?

Relationships are central because you can usually sense if something is wrong in one of the other fingers.



RULES (“Regler”): What rules should apply to our team? How do we make them useful and avoid restricting our opportunities? What useful experiences from other contexts do we have with rules?

The rule of thumb points out that it is important to express your expectations to each other. What seems obvious to one may not be for everyone.

How to carry out The Hand:

1. Make sure that the management have the necessary knowledge about the team's framework and direction to be able to perform the exercise on a qualified basis. Ask your leader to participate in the exercise if necessary.
2. Agree on who is in charge of the exercise and who writes notes on a computer along the way.
3. Review all five fingers together. For example, use the italicized questions above. Share the questions between the team members and let them reflect a few minutes by themselves. Meanwhile, the reporter writes the five thumbnails on a blackboard or five flip overs.
4. Allow the participants to explain one finger at a time. Note the participants' input on the tables as key words (possibly on post-its) - and as accurately as possible in the summary.

Take a break.

5. Let the reporter use the break to write a short agreement paper - based on what you have achieved - as far as possible with the words and expressions used by the participants themselves.
6. Print and hand out the agreement paper to all participants. Ask for their comments: Is there something that is misunderstood - or different than they thought?

End the meeting

7. After the meeting, process all comments in the original agreement paper and give the approved version to the participants.
8. Keep an eye on whether the agreement paper remains. Take it out on a regular basis, and check if you still follow your common principles of cooperation - and whether there is a need to adjust either the agreement or your practice. If subsequent changes to your expectations or conditions occur, you can repeat the process.

The role of the leader when working with this method

Working with The Hand you will discuss the framework and direction for teamwork among other things. This discussion takes place within the limits your management and organization have defined for teamwork. Therefore, ask your leader to give his answers to these questions - eg by attending the meeting where you discuss the principles of cooperation. You may also ask your leader for a period immediately after the meeting to pay particular attention to compliance with what you have done.

If subsequent changes to your expectations or conditions occur, you can repeat the process. Although the above method is used, problems may still occur in teamwork.

1. When issues and conflicts occur in the team

Here are five frequent issues, all of which require management involvement.

1. When the team's purpose or task is unclear
2. When functionality logic prevents development and rethinking
3. When family culture prevents feedback and dynamics
4. When conflicts occur in the team
5. When cooperation is not obtained

1. When the team's mission or task is unclear: A well-functioning team assumes that there are clear common expectations for the team's purpose and function in relation to the core task. Unless expectations are made clear by management, it is left to the individual team to define their own success criteria, which later may prove to be in conflict with management's unspoken expectations.

Unclear expectations for the team have three other consequences that can go beyond both efficiency and well-being in teamwork. Firstly, the team must spend time and effort guessing and negotiating what its mission, purpose and mandate is.

Secondly, the lack of clarity makes it difficult to assess whether the team's frames and resources actually match the purpose it has to fulfil.

Thirdly, uncertainty can signal a lack of managerial involvement in teamwork, which may seem demotivating - even though the definition of the task is sometimes left to the team precisely because management expects the team to have the necessary expertise in the field.

2. When everyday operations prevents development and innovation. The purpose of team organization is often to support and ensure better coordination and development, thereby contributing to the quality and effectiveness of the service. This easily comes in conflict with the train of thought that guides many work places. That is, an underlying culture that makes it most meaningful to prioritize the practical organization of the services and the solution of current and present problems. Logic of operation is often a cultural feature of the entire organization, which you do not think about in your daily life. Therefore, even in the individual team, it will be easily stand in the way for a more reflective approach to rethinking care and nursing as well as developing new methods.



There are two problems in this. Firstly, teamwork can be experienced as stealing time from the individual's own work. Secondly, too much of the team's time can come with acute practical and logistical coordination and too little of professional reflection and development.

A unilateral focus on the daily tasks risks can become a problem for the team. That is, if you only speak practical about what and how and never reflect together about why. In this case, the problem does not only mean that the team's work can be perceived as less meaningful - or even as a waste of time and energy. The consequence of a too dominant operating logic may also be that the team, organization and citizens miss the quality boost in the performance of the task and learning that could have increased job satisfaction and professional pride.

3. When family culture prevents feedback and dynamics. Many people appreciate a comfortable way of getting around and to enjoy each other's company. It often gives the individual a valuable confidence to be able to talk to good colleagues, reversing both personal and professional issues and being part of a collaborative team. There are many qualities in the family or consensus culture, but it can be problematic if the team is bound by common expectations of good personal relationships and a tolerable atmosphere. It can make it difficult to take the necessary and perhaps controversial professional discussions or to use a professional disagreement to become wiser and to lift each other's practices. Family culture can be a problem for team organization if members cannot inquire into each other's practice without being perceived as unfair criticism of a colleague's competence or an appeal to the good mood. In that case, teamwork will span one of its main purposes: to create good conditions for members' learning by supporting their mutual exchange of experience on the common task of delivering high quality service.

4. When conflicts occur in the team.

Team organization and other forms of work based on a high degree of self-management are often used to handle high complexity in organizations. The assumption is that complex tasks that require customized and tailor-made solutions cannot be controlled meaningfully from the management above. Therefore, responsibilities and tasks are delegated to employees and teams who are closer to the challenges. It often means that built-in opposites or dilemmas in the task solution move into teams. Even if the common purpose and the team's tasks are clear, disagreements or conflicts may occur, for example:

- Methods - i.e. which means, methods and procedures are best suited to achieve a particular goal for a citizen? It will often be up to a natural part of the team's task to consider and decide this.
- Values - for example, different professional or personal perceptions of what is right or wrong or that particular (subject) groups each have a perception of the values that the team should build upon or strive for.
- Resources - i.e. about the right priority, room, time, staff and other scarce resources. Who has the biggest real need? Do the individual members think of their own need or the team as a whole?



Conflicts about these issues are not necessarily bad. They can be a source of common professional clarification and development if handled properly - for example, in an open, respectful and problem-solving spirit. On the other hand, it may hurt the well-being of the team if the more task-oriented conflicts are supplemented with or evolve to:

- Role conflicts where roles and expectations internally in the team are not properly clarified. It often concerns how much management a team coordinator or manager must assume, or if some professions have a higher status than others do.
- Personal conflicts that may concern identity, self-worth, competition, rejection, breach of trust and other emotional discrepancies. It is often the conflicts that are both the most difficult for the team to handle and that affects the well-being - for the whole team and/or for the one of those who are caught up in it.

Many personal conflicts in teams happen because the framework of the work is not clearly defined, or that the team has to solve a task that in itself encounters conflicts. In this way, organizational or structural conflicts can end like personal conflicts.

5. When the cooperation is not lifted. One of the common reasons for teamwork is that it is an appropriate way to solve complex problems that require different knowledge and insight. By bringing more people with different areas of knowledge together, you expect the team to deliver better solutions than if the task was to be solved by individuals. You hope for a synergy effect: that $2 + 2 = 5$. The problem is if you are just hoping. Because there is no guarantee that, the synergy effects happen by itself. On the contrary, the opposite can happen immediately: $2 + 2 = 3$. It may difficult to reconcile different persons or professions. For example, because the participants in the team do not speak the same academic language or have different professional perspectives and experiences with the assignment. It takes time to learn how to work effectively together in a team - especially if the participants are very different. Therefore, the common results are not always as fast as the management or team itself had imagined, and that could easily become a source of frustration in and around the team.

Summary of unit 6

The professional's profile is that of the social and health helper and the social and assistants. The helper has following topic at school: meeting with the citizen, personal help, nursing and care and health promotion, prevention and rehabilitation.

The assistants has following topic at school: The meeting with the citizen and the patient, the coherent citizen- and patient care, quality and development, illnesses and nurse care (both physical and mental diseases), health promotion, prevention and rehabilitation and pharmacology and medicine management

Teamwork is necessary in nursing homes and long- term care, to give the citizens the best care. Research has shown that well-functioning teams provide higher efficiency, for example by to increasing the satisfaction of citizens, strengthen patient safety and reduce mortality. Through its resources, the team can solve tasks that cross professional and educational boundaries. It provides a much better utilization of the soft, professional and hard skills of the team.



However, it is not easy because conflicts of many different kinds can occur in the team. This needs leader support. The “hand” can help to resolve a conflict.

Questionnaires u6. Professionals profile and teamwork

Q1. Anyone can work sufficiently well in a nursing home

False

Q2. The social and health care helpers and the social and health care assistants all have the same competences

False

Q3. The social and health care assistants are the only ones who also works in hospitals

True

Q4. Teamwork is the most efficient when the team are well functioning

True

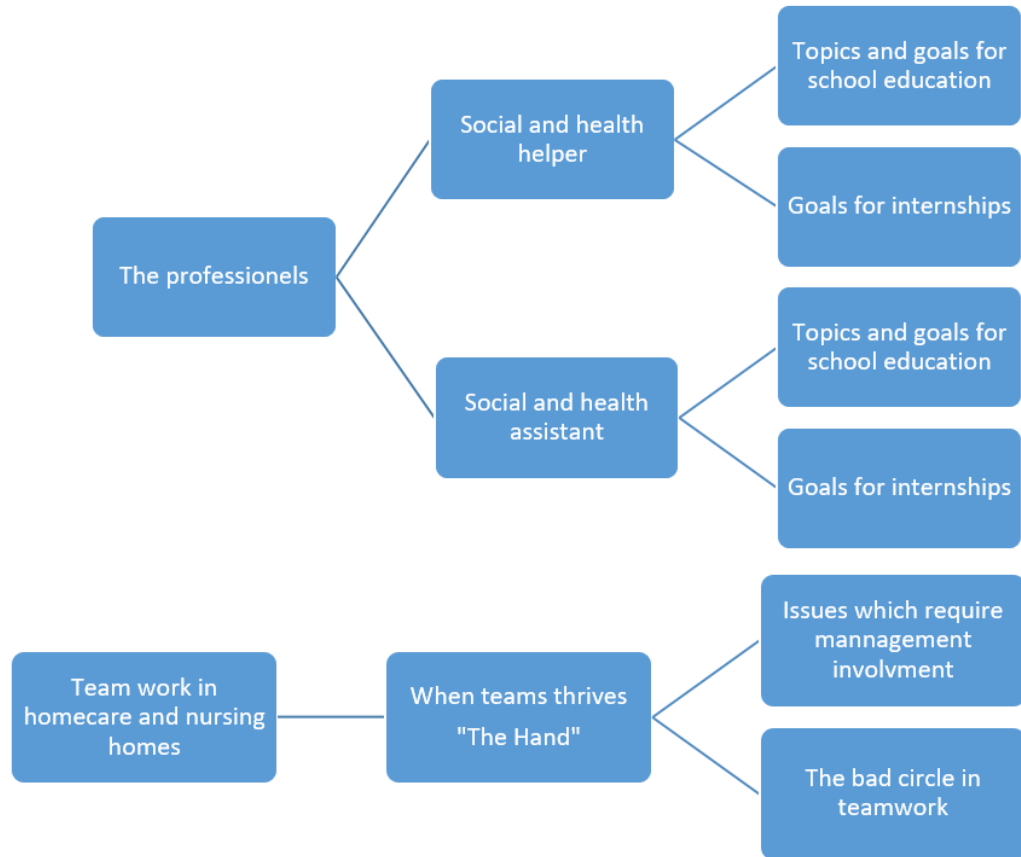
Q5. Teamwork is good when the leader stays away

False



Conceptual Map unit 6

CONCEPTUAL MAP UNIT 6





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